STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

April 2, 2007

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Irene Kazieczko, Director
Bureau of Community Mental Health Services
Mental Health and Substance Abuse Administration

SUBJECT: FY 2007/2008 Mental Health Block Grant Request for Proposals (RFP) **Proposal Application Deadline: May 24, 2007 at 12:00 noon**

Attached for your careful review and response is the Community Mental Health Block Grant RFP for adult services. This RFP is aimed at promoting the policy of the Michigan Department of Community Health to support our system transformation to one based on the fundamental principle of recovery for adults with mental illness. This system transformation effort is consistent with the recommendations of the Michigan Mental Health Commission, the state's Advisory Council on Mental Illness, and the Michigan Recovery Council. Community Mental Health Services Block Grant funds are targeted for development of new high-quality and culturally-relevant community-based services for adults with serious mental illness, as specified in the Michigan Department of Community Health (MDCH) plan approved by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS). The total funding available under this RFP is approximately $3 million.

Evidence-based practices funded under this initiative will be for two years, beginning October 1, 2007. A maximum of $140,000 in block grant funds is available for the two-year period.

Direct service projects funded under this initiative will also be for two years, beginning October 1, 2007. A maximum of $100,000 in block grant funds is available for the first fiscal year and a maximum of $50,000, with an equal contribution from the PIHP, is available for the second year. PIHPs must commit to continuation of the proposed services.

For training-only or one-time purchases for consumer-run drop-in centers or clubhouses, you may request a maximum of $75,000 in block grant funds for the fiscal year beginning October 1, 2007.

Funding is available for one CMHSP to provide statewide clubhouse training. Up to $75,000 in block grant funds is available for each of two years of funding, October 1, 2007 through September 30, 2008, and October 1, 2008 through September 30, 2009. No match dollars are required.

The PIHP's Improving Practices Leadership Team (IPLT) must assess and document the organizational capacity of the PIHP and its CMHSPs to support consumers in recovery as part of the preparation process for submitting a proposal(s). Review criteria are included in the RFP.

Only PIHPs are eligible to submit proposals in response to this RFP. A program person and a budget person at the PIHP, who are knowledgeable about the proposal and able to make changes if needed, must be identified on the face sheet.

An **informational meeting** for PIHP staff interested in responding to this RFP is scheduled for **Tuesday, April 17, 2007, from 1:00 to 4:00 p.m.**, at the Capitol Commons Center, 400 South Pine Street, Lower Level Conference Rooms E and F, in Lansing (see attached driving directions). We strongly encourage the participation of a program staff person and a fiscal staff person from each PIHP at this meeting. PIHPs that have affiliate CMHSPs may also want to invite a program and fiscal staff person from each of their respective agencies. For those unable to travel to Lansing (and for additional staff from each agency), there will be conference call-in availability. Please dial 1-888-582-3529 and when prompted, enter the following passcode: 6289210. Those desiring to participate by phone should contact Theresa Randleman at Randlemant@michigan.gov, and a copy of the power point presentation will be e-mailed prior to the meeting to allow participants to follow-along. A summary of questions and answers from the meeting will be compiled and posted on the MDCH website following the meeting.

If you have a current block grant project that was accepted as a two-year proposal (including the Practice Improvement Initiative), do not respond to this RFP for those projects. A separate request for second year budgets and work plans for those projects will be sent to you in June. Remember that second year funding is contingent on satisfactory performance during the current year and on the availability of funds.

Questions regarding this RFP should be directed to the specialist identified for each program area. Please immediately share this RFP with your program and financial staff.

Attachments

cc: Janet Olszewski
Patrick Barrie
Advisory Council on Mental Illness
Michigan Recovery Council
Improving Practices Leadership Teams
Practice Improvement Steering Committee
Mental Health and Substance Abuse Management Team

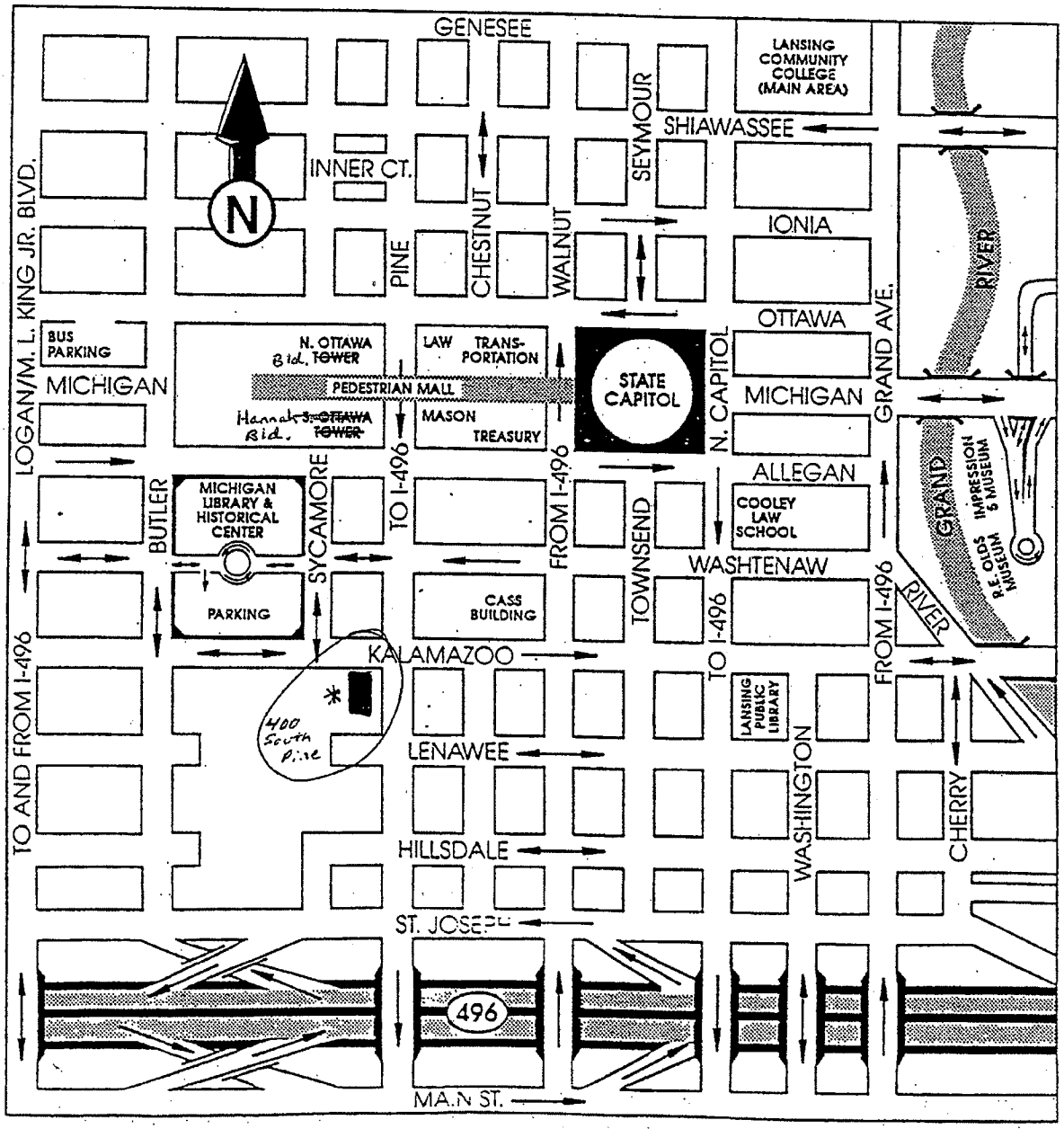
The Capitol Commons Center Building is located
at 400 South Pine Street, which is at the corner of Kalamazoo and Pine

Public parking for the Capitol Commons Center is available at the
Michigan Library and Historical Center on Washtenaw Street
(1/2 block from the Capitol Commons Center)

Limited parking is available in the parking lot immediately to the east of the
Capitol Commons Center Building

From I-96 or I-69, exit onto US-127 and proceed to downtown Lansing via I-496.

From I-496, exit onto Logan Street (Martin Luther King Blvd) **(M-99) and proceed north 4 blocks to Washtenaw Street. Turn right (east) onto Washtenaw to the Library's main entrance. Parking is available at the ticket booth just west of the traffic circle.**



MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF COMMUNITY MENTAL HEALTH SERVICES
COMMUNITY MENTAL HEALTH BLOCK GRANT
REQUEST FOR PROPOSALS - ADULT SERVICES

FY2007/2008
ONE-TIME ONLY FUNDING
SUBMISSION DUE DATE: MAY 24, 2007 AT 12:00 NOON

Attachments:
- Face Sheet
- Budget Pages
- COD:IDDT Template
- FPE Checklist and Template
- Competitive Proposal Narrative
- Statewide Clubhouse Training Proposal Narrative
- Dr. Steve Onken Recovery Presentation
- MDCH Policy Memo Regarding Recovery and Peer Support Specialists

Purpose

This RFP is aimed at promoting the policy of the Michigan Department of Community Health (MDCH), under the leadership of Director Janet Olszewski and the vision of Governor Jennifer Granholm, to support our system transformation to one based on the fundamental principle of recovery for adults with mental illness (see attached MDCH policy memo regarding recovery and peer support specialists). This system transformation effort is consistent with the recommendations of the Michigan Mental Health Commission, the state's Advisory Council on Mental Illness, and the Michigan Recovery Council. It is designed to address recommendations from these groups. MDCH is making available Community Mental Health Block Grant funding to Prepaid Inpatient Health Plans (PIHPs). Mental health transformation services and activities must be based in recovery, consumer driven, culturally competent and, as much as possible, utilize existing evidence-based approaches, practice-based evidence, and promising practices. The goal is for people to live satisfying, hopeful, and contributing lives.

At this time the recovery model is the most invigorating source of hope for system change. It is the conceptual prism through which we deepen our understanding of the primary goals and values for services to adults with mental illness. The PIHP's Improving Practices Leadership Team (IPLT) must assess and document the organizational capacity of the PIHP and its CMHSPs to support consumers in recovery as part of the preparation process for submitting proposal(s).

Requirement for Assessment of Recovery Environment

To meet the requirement to assess the organization's recovery environment, PIHPs may convene discussion groups with primary consumers to discuss organizational practices currently in place that may help or hinder recovery and identify opportunities and priorities for change. Elements to include in the discussion process are summarized in "Mental Health Recovery: From Research and Theory to Practice, Dr. Onken presentation to MDCH 2006" (attached). IPLTs may also begin to assess the recovery environment by utilizing tools such as the ROSI Consumer Survey or others described in, Measuring the Promise: A Compendium of Recovery Measures, Volume II, produced by the Evaluation Center at the Human Services Research Institute, http://tecathsri.org under featured tool kits. It is expected that proposals submitted in response to this RFP relate to information learned and a need for change identified. MDCH also recognizes the need to examine its recovery focus and is engaging in a similar process.

MDCH, in conjunction with the activities of the Michigan Recovery Council, is issuing a separate RFP to establish a Recovery Center of Excellence. It is expected that this center will provide technical assistance to the public mental health system to support the transformation to a recovery-based system of care as part of this process.

Funding Amount Available and Contract Period

It is expected that total funding of approximately $3 million will be available for new projects proposed in response to this RFP. All direct service proposals must be submitted for a two-year period. There is no limit as to the number of proposals that can be submitted, but PIHPs must assure all submitted proposals meet the proposal criteria.

It is the responsibility of PIHPs that have affiliate CMHSPs to include those CMHSPs in this process. Such PIHPs will provide overall leadership and coordination with the IPLT.

Types of Proposals Requested

There are three types of proposals being sought, and three corresponding sections to this RFP:

- Non-competitive Evidence-Based Practice Proposals – Two years
- Competitive Proposals – Two years for service proposals and one year for training or consumer-run program support proposals
- Competitive Proposals for Statewide Clubhouse Training – Two years

NON-COMPETITIVE EVIDENCE-BASED PRACTICE PROPOSALS

The May 23, 2005 Mental Health System Transformation Practice Improvement Infrastructure Development Request for Proposals allowed PIHPs to apply for block grant funds to establish Improving Practices Leaderships Teams and to implement one or both of two evidence-based practices (EBPs) for adults. All PIHPs currently have contracts that include Family Psychoeducation and/or Co-occurring Disorders: Integrated Dual Disorders Treatment.

PIHPs that would like to begin implementation of the practice for which they are not currently funded may apply for two years of block grant funding for the period of October 1, 2007 through September 30, 2008 and October 1, 2008 through September 30, 2009. A maximum of $140,000 over the two-year period is available for these projects.

If a PIHP has already implemented both Family Psychoeducation and Co-occurring Disorders: Integrated Dual Disorder Treatment as described in the May 23, 2005 Mental Health System Transformation Practice Improvement Infrastructure Development Request for Proposals, it may be eligible to apply for funding to implement the evidence-based practice of Supported Employment on a non-competitive basis. Please contact the program specialist for the practice for which the PIHP has not had a specific improving practices block grant contract to determine if you will be eligible to apply for Supported Employment.

It is expected that by fiscal year (FY) 09/10 there will be a contract requirement that both Family Psychoeducation and Co-occurring Disorders: Integrated Dual Disorder Treatment practices, as implemented under the systems improvement process, will be available throughout each PIHP region.

Any PIHP that receives block grant funding for a practice will be required to have a representative serve on the PIHP's Improving Practices Steering Committee's Subcommittee for that practice. PIHPs should refer to the "Use of Block Grant Funds" in the competitive section of this RFP as the same requirements apply to non-competitive proposals.

Proposal Requirements for Non-Competitive Proposals:

The PIHP must submit:

- A summary of the IPLT's recovery assessment process, key findings, and how this proposal will assist the PIHP in becoming more recovery oriented.

- A proposal face sheet.

- An IPLT listing, including team member roles and e-mail addresses. Please note that the PIHP should have an identified program leader for each practice it has implemented or will be implementing next fiscal year.

- A workplan that addresses the project period of October 1, 2007 through September 30, 2008, and a separate workplan addressing October 1, 2008 through September 30, 2009. The workplans for both years should include specifies goals, measurable objectives, and concrete activities that will be achieved during each quarter. DO NOT include reference to any proposal language or attachments in the documents because the year one workplan will become part of the contract. All pertinent workplan information must be included in the workplan itself.

- For Co-occurring Disorders: Integrated Dual Disorder Treatment – Template for PIHP Planning and Implementation with narrative for each of the 20 items and a workplan that addresses all template items that will be worked on during the contract period beginning with those that are not yet completed.

- For Family Psychoeducation – Template for PIHP Planning and RFP Checklist.

- For Supported Employment, documentation of implementation of Co-occurring Disorders: Integrated Dual Disorder Treatment, including the system development work and a workplan based on the Requirements for Funding for Supported Employment.

- A Program Budget Narrative, which explains expenditures and provides rationale.

- A Program Budget Summary and Program Budget Cost Detail. MDCH forms 0385 and 0386 are contained in Attachment B of this RFP and the most current versions are accessible from the MDCH website at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, click on Mental Health and Developmental Disability, click on Requests for Proposals and Grants.

Non-Competitive Proposals by Program Areas:

CO-OCCURRING DISORDERS: INTEGRATED DUAL DISORDER TREATMENT

Tison Thomas (517) 241-2616 thomasti@michigan.gov

In June 2004, MDCH, together with the PIHPs, consumers, major universities, and other stakeholders, came together to discuss improving clinical practices in the mental health system. This group, now called the Practice Improvement Steering Committee, decided to implement federal Substance Abuse and Mental Health Administration (SAMHSA) approved evidence-based practices (EBPs) in Michigan.

The Practice Improvement Steering Committee recommended Co-occurring Disorders: Integrated Dual Disorder Treatment (COD:IDDT) as one of the EBPs to be implemented across the public mental health system. MDCH accepted this recommendation from the steering committee and issued a Request for Proposals to PIHPs (Infrastructure Development Block Grant RFP May 2005), offering the use of limited block grant funds to develop infrastructure related to EBPs and to implement selected EBPs.

To implement the IDDT EBP, PIHPs need to look at the system as a whole. This means that their system needs to address the issues and barriers that consumers with complex needs face every day. In Michigan, MDCH uses the principles of the Continuous, Comprehensive Integrated System of Care model developed by Dr. Ken Minkoff and Dr. Chris Cline to effectively change the systems.

COD:IDDT is for people who have a co-occurring serious mental illness and substance disorder. This treatment approach helps people recover by offering treatments that integrate mental health and substance abuse interventions at the level of the clinical encounter. This means the same clinicians or team of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in an integrated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a co-occurring disorder, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of integrated interventions is recovery from two (or more) serious illnesses.

A wide variety of services are offered in a stage-wise fashion because some services are important early in treatment, while others are important later on. Individualized treatment is offered depending on what stage of recovery a person is in. Services are offered in a positive atmosphere and people are encouraged to believe that they can recover as many others have. Ultimately, the goal of integrated systems and integrated services, including COD:IDDT is to help people manage both their mental illness and substance disorders so that they can pursue their own meaningful life goals.

The action plans developed by the COD:IDDT subcommittee workgroups are aimed at supporting communities in implementing integrated treatment through a quality improvement process. Tools for navigating the complexities of our systems are provided so that implementation of this practice will not be avoided or delayed because of those complexities. Expectations include the following:

- Resources and technical assistance will be available to PIHPs to promote systems change that supports integrated treatment. PIHPs can identify this EBP as a project in the next year regardless of their stage of systems change.
- Resources and technical assistance will also be available for those PIHPs who are ready to implement the SAMHSA Toolkit for IDDT for adults with a serious mental illness.
- PIHPs that identify this EBP as a project will be asked to complete a self-assessment using the CO-FIT for their system, and develop action plans based on this self-assessment.
- MDCH monitoring of the PIHP's progress related to this EBP will be based on each PIHP's progress on their action plans. State monitoring will not be based on compliance with EBP toolkit standards.
- The EBP COD:IDDT Measurement Workgroup Subcommittee will be identifying indicators and tools for evaluation and measurement. The information from this data will be used for local and state quality improvement efforts, not contract compliance purposes.
- Stakeholder participation in this effort is important. Consumer participation and substance abuse and mental health system participation is expected throughout. Participation from PIHP project sites is important in implementing and promoting this EBP in the State of Michigan. PIHPs implementing the practice are required to have at least one active member of the Co-occurring Disorder Subcommittee of the Practice Improvement Steering Committee. The group is asked to share information, and assist in identifying and addressing implementation issues and technical assistance opportunities. Sharing of experiences by participants allows individual PIHPs and affiliates, as well as the entire state system, to move forward more smoothly and with more consistency.
- A team of fidelity assessors called the Michigan Fidelity Assessment Team (MiFAST), comprised of selected PIHP and university staff, is coordinated by Wayne State University. This team is to be used by all PIHPs to perform fidelity reviews of COD:IDDT teams as they are formed.

Completing the Co-occurring Disorders: Integrated Dual Disorder Treatment – Template for PIHP Planning and Implementation.

The steps identified in the COD:IDDT Template for PIHP Planning and Implementation (attached) are considered essential elements, and a logical progression, in developing first the system capacity and then the EBP itself. PIHPs applying for funding for this practice must complete this template, indicating which activities are accomplished, in the planning process, or not yet begun. Please note that many activities that are "accomplished" are ongoing activities needed to sustain the practice.

A PIHP is eligible for funding for this practice regardless of where it is in the planning process. It may be at the beginning, somewhere in the middle, or nearer to complete implementation. The workplan must address how the PIHP will use block grant funds to accomplish the next steps in the process.

FAMILY PSYCHOEDUCATION

John Jokisch (517) 335-0244 jokisch@michigan.gov

Family Psychoeducation (FPE) is a specific method of working in partnership with consumers and families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling problems posed by mental illness. The goal is that the practitioner, consumer, and family work together to support recovery. Common issues include participation in outpatient programs, understanding prescribed medication, alcohol or other drug abuse, and symptoms that affect the consumer. FPE respects and incorporates individual, family, and cultural perspectives. It engenders hope in place of desperation and demoralization and can significantly help people with a mental illness in their recovery process.

The Practice Improvement Steering Committee established by MDCH during FY05 has an FPE Subcommittee that has developed a strategy for assisting PIHPs who choose to implement FPE. Participants on the subcommittee include consumers, and representatives from PIHPs that are currently implementing FPE. The subcommittee also includes representatives from the University of Michigan who are assisting PIHPs with fidelity monitoring and development of outcome evaluation strategies.

PIHPs submitting proposals for FPE should be knowledgeable about the FPE model developed by the National Evidence Based Practices Project. This model is based on the work of Dr. William McFarlane. The PIHP will utilize the fidelity scale contained in the toolkit as part of its quality improvement program. As with other EBPs, there are the expectations that:

- MDCH monitoring of this EBP will be based on each PIHP's progress on their workplans. State monitoring will not be based on compliance with EBP Toolkit standards.
- The Measurement Workgroup will be identifying indicators and tools for evaluation and measurement related to this EBP. However, the information from this data will be used for local and state quality improvement efforts, not contract compliance purposes.
- Stakeholder participation in this effort is important. MDCH will continue to encourage consumer participation and PIHP participation throughout the course of the project.
- Participation from PIHP project sites is important in implementing and promoting this EBP in the State of Michigan. PIHPs will be asked to assist in identifying and addressing implementation issues by participating in workgroups and technical assistance opportunities throughout the course of the project.

Specific Requirements for Funding for Family Psychoeducation:

1. PIHP convenes meetings with stakeholders, including advocacy and consumer groups.
2. PIHP identifies a program leader for Family Psychoeducation.
3. PIHP forms an ongoing workgroup of clinicians, consumers, and administrators to address the implementation and obtaining continuous feedback.
4. PIHP develops a consensus building process around the SAMHSA Resource Kit. This includes model fidelity and implementation strategies, disseminating program documents, and developing training plans for the staff.
5. PIHP develops, revises, and implements workflow and other administrative processes, including information system requirements.
6. PIHP provides or arranges for ongoing technical assistance and training needs for the staff and/or providers.
7. PIHP develops defined competencies for clinical staff.
8. PIHP uses General Organizational Index and fidelity scales at regular intervals to evaluate the model fidelity of the program.
9. PIHP identifies areas of needed clinical improvement and works with workgroups to address needs.
10. PIHP shares successes and barriers in implementing FPE with MDCH EBP Steering committee and other regions.

PIHPs that are submitting proposals for assistance with implementation of FPE must submit a workplan that addresses the activities, milestones/dates, person responsible, and outcomes. This is included in the Family Psychoeducation Template for PIHP Planning (attached). In addition, PIHPs must complete the items on the Family Psychoeducation RFP Checklist (attached).

SUPPORTED EMPLOYMENT

This practice is available for block grant funding on a non-competitive basis only to PIHPs that have already implemented both Co-occurring Disorders: Integrated Dual Disorder Treatment and Family Psychoeducation. Documentation as described above must be submitted with this proposal. (Please note that any PIHP is eligible to apply for such funding in response to the competitive portion of this RFP).

Su Min Oh (517) 241-2957 ohs@michigan.gov

Supported Employment is an approach to vocational rehabilitation that emphasizes helping people obtain competitive work in the community, and providing the supports necessary to ensure success at the work place. The principles and critical elements of supported employment and practices involve rapid job search, job tailored to individuals, time-unlimited following supports, integration of supported employment and mental health services, and zero exclusion policy.

Supported Employment is one of the evidence-based practices for people with serious mental illness that have demonstrated positive outcomes in multiple research studies. It consists of the following:

1) A Competitive Job is the Goal: The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs. These jobs are owned by the worker rather than the employment program.
2) Rapid Job Search: There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences such as prevocational work units or transitional employment. The consumer sets the pace for the job search; employment specialists help make contact with employers in the community.
3) Consumer Preferences are Important: Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences. Preferences may include personal interests or type of work, work environment, location, number of work hours per week, preferences for disclosure of disability, type of job supports, and accommodation.
4) Time-unlimited Support: Individualized supports to maintain employment continue as long as consumers want the assistance. They may include problem solving, symptom management, social skills training, feedback from employers and workplace accommodations.
5) Supported Employment is Integrated with Mental Health Services: Employment specialists coordinate plans with treatment team. This may require that mental health staff and employment specialists have offices in the same location, meet at least weekly to share expertise, and plan services with consumers.
6) Zero Exclusion Policy: All consumers who want to work are eligible for help. No one is excluded for reasons such as mental health symptoms, substance use, poor work history, and treatment non-adherence.
7) Individualized Benefits Planning: Personalized benefits planning and guidance help consumers to make informed decisions about the effects of earned income upon their benefits.

The PIHP should be knowledgeable about the Supported Employment model developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The PIHP will utilize the fidelity scale contained in the toolkit as part of its quality improvement program.

Requirements for Funding for Supported Employment:

1) PIHP convenes meetings with stakeholders, including consumers, case management, residential, psychiatry, and other clinical services that compose the treatment team.
2) PIHP identifies a program leader for Supported Employment.
3) PIHP forms an ongoing work group of consumers, clinicians, and administrators to address the implementation and obtaining continuous feedback.
4) PIHP develops an action plan for implementation of the Supported Employment Resource Kit. This includes model fidelity and implementation strategies, and develop training plan for the staff.
5) PIHP identifies steps to develop integration between Supported Employment and Mental Health Treatment at consumer, team, supervisory, leadership, and organizational level.
6) PIHP provides ongoing technical assistance and training needs for the staff and/or providers.
7) PIHP uses General Organizational Index and Fidelity Scales at regular intervals to evaluate the model fidelity of the program.

8) PIHP identifies areas of needed clinical improvement and works with work groups to address needs.
9) PIHP shares successes and barriers in implementing Supported Employment.

Recommended Resources:

Deborah R. Becker and Robert E. Drake, (2003) A Working Life for People with Severe Mental Illness. New York: Oxford University Press, Inc.

Supported Employment Implementation Resource Kit:
http://www.mentalhelath.samhsa.gov/cmhs/communitysupport/toolkits/employment/default.asp

Office of Employment Support Programs: http://www.ssa.gov/work

Dartmouth Psychiatric Research Center: http://dms.dartmouth.edu/prc/employment

Ohio Supported Employment CCOE: http://www.ohioseccoe.case.edu

COMPETITIVE PROPOSALS

The maximum block grant funding amount available per direct service project for the first year, October 1, 2007 through September 30, 2008, is $100,000. For the second year, October 1, 2008 through September 30, 2009, the PIHP and/or CMHSP must commit other public funding it manages to the project; this amount must equal 50% or more of the total project budget. A maximum of $50,000 in block grant funds will be available for the second year of direct service projects. Second year funding for two-year projects will be contingent upon satisfactory progress achieved during the first year as well as the availability of funds.

Proposals for training purposes or for one-time assistance for consumer-run programs may be submitted for one year, October 1, 2007 through September 30, 2008. A maximum of $75,000 in block grant funds may be requested for these projects; generally such requests are a much smaller amount. PIHP and or CMHSP financial participation in these budgets is encouraged.

The proposal narrative must be submitted in the format attached to this RFP. The components of the narrative, as well and the budget and budget narrative, tie directly to the review criteria.

The face sheet (Attachment A) contains lists of both program areas and target populations. This year PIHPs are requested to type in the primary program area and then check as many related categories as apply to each proposal.

Program Areas and Target Populations:

Anti-Stigma
Assertive Community Treatment (ACT)
Clubhouse Programs
Consumer Run, Delivered, or Directed Innovations

Co-Occurring Disorders: Integrated Dual Disorder Treatment (IDDT)
Cultural Competence / Special Populations
Adults with Dementia
Family Psychoeducation
People who are Homeless
Jail Diversion
Older Adults
Certified Peer Support Specialists Staff Development
Recovery System Change
Supported Employment
Supported Housing
People with a History of Trauma
Other (specify)

Continuation

The PIHP and/or CMHSP must agree to continue direct service projects funded under this RFP after the grant period. Each proposal must address how the elements of the project will be continued at the end of the block grant funding period. For example, a service may be designed to take the place of a less successful service, which should be identified in the proposal. Or the project may be continued with funds saved through administrative efficiencies. Note: The statement of continuation must be from the PIHP and/or CMHSP, not the provider.

Proposal Reviews

Proposals will be reviewed by a team of at least three people, consisting of one or more consumer of mental health services and the program area specialist.

Target Population

Funding provided under this RFP must be used for adults with serious mental illness (SMI). PIHPs are encouraged to use it to improve services for adults with SMI who also have co-occurring substance disorders.

Use of Block Grant Funds

Consistent with federal and Michigan Mental Health Commission directions for state transformation activities, Community Mental Health Block Grant funds are to be used for activities designed to improve the system of care by promoting recovery. Transformational activities include the provision of evidence-based practices and innovative and promising practices, and the promotion of consumer-driven mental health care. All activities must be built around and consistent with person-centered planning principles and practices. Consumers must have an informed choice regarding their service(s).

Federal mental health block grant funds may not be used to supplant existing mental health funding. It may not be used to fund Medicaid approved services for Medicaid recipients.

Federal authorizing legislation specifies that these funds may not be used to:

(1) provide inpatient services;
(2) make cash payments to intended recipients of mental health services (e.g., stipends, rent or lease payments, utility arrearages, insurance, furnishings, etc.);
(3) purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or
(5) provide financial assistance to any entity other than a public or nonprofit private entity.

MDCH contracts require that any service or activity funded in whole or in part with this funding be delivered in a smoke-free facility or environment.

In addition, this RFP emphasizes the mental health block grant's emphasis upon service provision, and the following restrictions are also included:

(6) no medication purchases;
(7) no vehicle purchases, leases, or insurance; and
(8) no administrative or indirect expenses.

Note: There are three ways in which block grant funds may be used for project staffing so that no supplanting occurs:

- if the position is a new hire;
- if the position is assuming additional hours (i.e., part-time to full-time) and block grant funds are paying for the additional hours only; or
- if an existing staff member is assuming the duties of the new project and their old position will be back-filled with a new hire.

Review Criteria for Proposals Submitted in Response to this Request

Screening Review Criteria (all must be met to be eligible for scored review):

1. Consumers had meaningful involvement in the process used to identify the need for the proposed project. The project will support consumers in the recovery process.

2. The IPLT assessed the organizational capacity of the PIHP and its CMHSPs to support consumers in recovery. The PIHP has included a summary of this assessment process, key findings, and how this proposal will assist the PIHP in becoming more recovery oriented.

3. The proposal meets all special requirements contained in the programmatic specifications for the category for which this proposal is submitted.

4. For services projects, there is a firm commitment from the PIHP/CMHSP that the services will continue after grant funds have ended. Positions for consumers funded under the proposal will remain in place after the grant period is over.

5. PIHP and CMHSP history of continuing previous block grant project (funded in fiscal year 04/05 and/or 05/06) demonstrates commitment.

The Scored Review Criteria are included in the Proposal Narrative attachments.

Proposal Requirements for Competitive Proposals:

The PIHP must submit:

- A summary of the IPLT's recovery assessment process, key findings, and how this proposal will assist the PIHP in becoming more recovery oriented.

- A proposal face sheet for each project request.

- A Proposal Narrative in the attached format. Please number each section to match the attached document. This narrative is limited to ten (10) pages.

- A workplan for each project request, that addresses the project period of October 1, 2007 through September 30, 2008, including specifies goals, measurable objectives, and concrete activities that will be achieved during each quarter. DO NOT include reference to the proposal narrative or its attachments in the documents because the year one workplan will become part of the contract. All pertinent workplan information must be included in the workplan itself.

- A detailed Program Budget Narrative, which explains expenditures and provides rationale. NOTE: Please also include a detailed description of any provider or subcontractor expenses listed on the contractual line.

- A Program Budget Summary and Program Budget Cost Detail. MDCH forms 0385 and 0386 are contained in Attachment B of this RFP and the most current versions are accessible from the MDCH website at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, click on Mental Health and Developmental Disability, click on Requests for Proposals and Grants.

The following additional information must be included in proposals for two-year projects:

- A separate second-year workplan that addresses the project period of October 1, 2008 through September 30, 2009, which includes specifies goals, measurable objectives and concrete activities that will be achieved during each quarter of the proposed second year.

- A Program Budget Narrative for the proposed second year of the project, which explains expenditures and provides rationale.

- A Program Budget Summary and Program Budget Cost Detail for the second year of the proposed project period.

- A composite Budget Summary for the two-year period.

Submission Method and Due Date

One original plus four copies of all proposals, including the signed face sheet, must be received at the Department of Community Health to the attention of Karen Cashen, Adult Block Grant Coordinator, at the address listed below by **12:00 p.m. on May 24, 2007**. In addition, an electronic copy of each proposal, with an electronic copy of the face sheet, must also be submitted to Karen Cashen at cashenk@michigan.gov by **12:00 p.m. on May 24, 2007**. The mailing address is:

Karen Cashen, Adult Block Grant Coordinator
Department of Community Health
Bureau of Community Mental Health Services
320 S. Walnut, 5th Floor
Lansing, MI 48913

Note: All electronic documents, with the exception of the signed face sheet, support letters, or interagency agreements, must be submitted in Microsoft Word or Excel. Signatures other than the CMHSP director (if applicable) and the PIHP director will not be accepted. If you have general questions about the RFP, please contact Karen Cashen at (517) 335-5934 or e-mail at cashenk@michigan.gov

Competitive RFP by Program Areas:

ANTI-STIGMA

Colleen Jasper (517) 373-1255 jasper@michigan.gov

Stigma is the number one barrier to recovery and receiving mental health care. Stigma has many forms and exists widely in both the system and the community. The best way to combat stigma is through interpersonal connections. In other words, hearing the voices and stories of individuals who have directly experienced mental health problems is the best way to change and alter people's attitudes about mental illness.

Initiatives involving consumers who portray realistic viewpoints of mental illness are essential in fighting stigma and also enhancing their own self-esteem and recovery. Involvement of consumers in the development and implementation of these projects is essential. Proposals, including ways of fighting stigma, such as: videos, educational meetings, community participation forums, etc., are encouraged.

ASSERTIVE COMMUNITY TREATMENT (ACT)

Alyson Rush (517) 335-0250 rusha@michigan.gov

Current minimum criteria for ACT services in Michigan are contained in the Michigan Medicaid Provider Manual. For ACT services to be truly evidence-based, they must meet the fidelity criteria contained in the ACT federal Substance Abuse and Mental Health Administration (SAMHSA) approved evidence-based practice ACT Implementation Resource Kit (tool kit). The soon to be issued Michigan ACT Field Guide provide assistance to ACT teams and their supporting PIHPs and CMHSPs in moving toward the evidence-based practice criteria. It is expected that over time, Michigan Medicaid criteria will mirror the evidence-based fidelity criteria.

Proposals are invited that will move ACT teams to meeting evidence-based practice criteria. Specific reference must be made to the areas in the fidelity criteria that will be implemented. There areas must be beyond the current Michigan Medicaid standards, which are already required.

In addition to block grant funding availability under this RFP for ACT service improvement, ACT-specific training is offered at no cost to all ACT teams in Michigan through the Federal Mental Health Block Grant; ACT specific training is a requirement of the current Medicaid Provider Manual. Agencies and teams receive training information and registration materials provided through the Assertive Community Treatment Association (ACTA) and can find it on the website at www.actassociation.org. Participation for a specified number of registrants for each training will be funded for members of Michigan ACT teams by the MDCH through block grant funds. Additional spaces, as well as spaces for those who are not members of Michigan ACT teams, may be available on a fee-for-training basis. Many of the trainings offer continuing educational credits. Training materials and refreshments are provided, as is lunch for all-day sessions; transportation is not included in the training and must be provided through the individual agency.

CLUBHOUSE PROGRAMS

Su Min Oh (517) 241-2957 ohs@michigan.gov

Improving Employment Outcomes

One way of measuring effective clubhouse programs is to examine the number of individuals who are receiving employment services and supports. Employment is a guaranteed right of membership. Assistance in moving members toward full-time employment is needed. Proposals are requested for innovative and creative initiatives to enhance the employment opportunities for clubhouse members. Proposals must address evidence of long-term support for employment. Initiatives must include a benefits planning component so that consumers have information about how work activity will impact their ability to maintain benefits. The proposal must provide background information on how many people the clubhouse services, the percentage of individuals who were in an employment situation in the past year, what the desired outcomes are and a plan to achieve them.

Clubhouse Long-Term Housing Supports
Clubhouse members living in adult foster care may be living in residential environments that provide limited opportunities to lead a self-determined life. This initiative will target persons currently living in adult foster care and wishing to live independently or with roommates of their own choosing. Through the development of a clubhouse housing unit, members and staff will provide assistance with transition issues, locating housing, furnishings, etc., and provide long-term support for members living independently in the community. Block grant funds cannot be used to subsidize rent or security deposits, or pay for utilities or insurance (or any other expenditures which would constitute cash payments to or for consumers). Anticipated outcomes may include increased activity of the clubhouse program through the development of a housing unit, increase in the number of members living independently/decrease the number of persons living in dependent (foster) care, and/or increased consumer satisfaction and quality of life.

Clubhouse Start-Up, Site Development and Operational Supports
Proposals can be submitted for limited one-time only funding support for furnishings, equipment, and minor renovations for new or existing clubhouse programs. Priority will be given to newly developing clubs and those moving to an off-site location. Itemized budget detail must be included in the proposal.

ICCD Clubhouse Training
This training is targeted for **new** clubhouse programs or new managers of existing clubhouse programs. This training group must include (1) the clubhouse manager, (2) one clubhouse staff, (3) one clubhouse member, and (4) PIHP administrator/supervisor attending the third week. The block grant award covers the fixed tuition and lodging cost of $4,800 and $1,500 toward transportation and meals related to the training. Funding support over and above the block grant award is the responsibility of the PIHP. Block grant funds cannot be used for clubhouse members or staffs that have already participated in block grant funded training. The proposal should indicate the target date and location for their training. Available training dates can be found at www.iccd.org.

CONSUMER RUN, DELIVERED, OR DIRECTED INNOVATIONS

Michael Jennings (517) 335-0126 jennings@michigan.gov

Proposals targeted at the development of innovative, new consumer-run, delivered, or directed initiatives are encouraged, such as, Project Stay, person-centered planning within a drop-in center setting, peer case management support, Peer Support Specialist integration into consumer-run or directed activities or services, and statewide resource development. Rural service activities and outreach efforts services directed toward special populations are encouraged. Please note that it is expected that all proposals directed toward consumer-run initiatives address Consumer-Run, Delivered, or Directed Initiatives.

Additional information regarding consumer-run programs can be obtained at the websites on recovery noted in this RFP and at Consumer Operated Services Program: Multi-site Research Initiative at www.cstprogram.org.

Drop-In Program Development or Enhancement
Proposals targeted at enhancement of existing drop-in centers, or the development of a new drop-in initiative where interest and the ability to promote consumer independence and growth are indicated will be considered. Proposals must identify and explain how gaps in the system or care are preventing consumers with serious mental illness from achieving their goal of recovery. If proposals are for the development of transportation supports (do not include vehicle purchases, lease, or insurance), maintenance, and the provision of support of current consumer programs in the area of equipment, computer training, furniture, and supplies that will enhance the facility are submitted, the proposal must address how these services, activities, or items will fill identified gaps and what specific outcomes can be expected and documented. These outcomes should be related to systems transformation and assisting consumers in achieving and maintaining recovery.

Any service or activity funded in whole or in part with this funding must be delivered in a smoke-free facility or environment. All proposals submitted will be required to document that this provision has been met and that a process for monitoring is in place and enforced. Block grant resources that are requested for capital outlay or renovations that cannot be removed and transferred to another site will not be considered. Also, block grant funds cannot be used to pay for building insurance.

Proposals under this program are intended to be a partnership between the PIHP/CMHSP and the consumer run drop-in. Proposals should reflect that partnership by showing a collaborative development of proposals, sharing of budget information, narrative program implementation, and by supplying a sub-agreement or sharing of the grant award contract when awards are made. Proposals should show that both the CMHSP and the consumer groups are equally involved in the total preparation and implementation of any grant initiatives.

Proposals under this program area should be able to demonstrate through the proposal submissions, quarterly narrative progress reports, and the evaluation plan that the intended intervention helps address the values of the public mental health system to reduce stigma, promote recovery, facilitate independence, personal responsibility, and allows for full participation in community life, promotes consumer choice, and maximized the opportunity for consumer autonomy and peer directed and run service alternatives. It is the intent that block grant support in this area can demonstrate outcomes which support systems transformation and consumer recovery that is the goal of the block grant effort. Evaluation of proposals should reflect the goals and objectives of the project and how they fit into a system transformation.

CO-OCCURRING DISORDERS ENHANCEMENT

Tison Thomas (517) 241-2616 thomasti@michigan.gov

Funds are targeted for those PIHPs that have already received block grant fund for IDDT implementation through the infrastructure development block grant and seek further assistance in enhancing integrated treatment services and approaches. If the PIHP has already implemented COD:IDDT through their own initiative and would like to apply for the Co-occurring Disorder Enhancement grant, please answer the following questions and submit them with your proposal:

1. Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?

2. Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).

3. Describe participation and involvement within your system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.

4. Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?

5. How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward integrated treatment capacity. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?

6. How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities?

7. What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.

8. If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.

9. What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team?

10. What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

11. What internal administrative or clinical barriers have you encountered and what efforts have you made to overcome them? What technical assistance have you received?

Proposals must address additional PIHP efforts to enhance this initiative and must contain the following:

- The application must be supported by the PIHP Improving Practices Leadership Team.
- If the PIHP received the infrastructure development block grant during fiscal year 2006 and 2007, please describe what the PIHP achieved through the infrastructure development block grant and describe where the PIHP is with the 20 step process identified in the May 2005 Request for Proposals.
- The PIHP must describe how it coordinates each of the proposed activities with the PIHP COD work teams and involving consumers with COD in decision-making process.
- The PIHP/CMHSP must work with the state COD:IDDT subcommittee.
- State how the PIHP is addressing the need for individuals with COD in all policies, funding mechanisms, regulations, and programming.
- State how the PIHP is promoting seamless delivery of integrated treatment through a variety of providers and systems (i.e., incorporating welcoming principles).
- PIHP screening, assessment, and treatment planning must address COD (the treatment plan developed through person-centered planning must address both mental health and substance disorders and ensure the goals and objectives match the consumer's stage of recovery).

Proposals are also invited to address the following:

- Developing stages of change and stages of treatment model when treating consumers with COD.
- Collaboration with multiple human service agencies, housing, criminal justice system and related agencies to meet the complex needs of the individuals.
- Developing multiple points of entry (no wrong door) and be perceived as caring and accepting by the consumer.
- Consumers receive comprehensive COD services and to develop integrated treatment approaches for the entire service array.
- Developing peer-delivered services for individuals with COD and to develop self-help groups.

- Developing innovative programs and staff components for individuals with co-occurring disorders. This includes dry, damp and wet housing.

CULTURAL COMPETENCE / SPECIAL POPULATIONS

Tison Thomas (517) 241-2616 thomasti@michigan.gov

Cultural Competence

Culture is critical in determining what people bring to the clinical setting, the language they use, how they express and report their concerns, how they seek help, the development of coping styles and social supports, and the degree to which they attach stigma to mental health and substance abuse problems.

Cultural competence in behavioral health is a commonly used concept referring to an innovative approach to the delivery of mental health services for minority populations. Its general objectives are to provide quality services for culturally diverse populations, including culturally appropriate outreach, location of services, engagement, assessment and interventions.

The President's New Freedom Commission on Mental Health report, "*Achieving the Promise: Transforming Mental Health Care in America*" calls for improving access to quality care that is culturally competent. The President's report also stated that the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often undeserving or inappropriately serving them. Culturally competent services are defined as "the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values."

Research and data indicates that cultural competence is essential to quality of care, responsiveness of services, and renewed hope for recovery among ethnic and racial minorities. Racial and ethnic minorities are seriously under represented within the core mental health professionals. Further the existing workforce is inadequately prepared to provide services to culturally diverse populations.

The prominence of culture, however, is not limited to the persons seeking help. Culture is also applicable to providers of services. Each group of providers and each system of service delivery embodies a culture of shared beliefs, norms, values and patterns of communication. These groups may perceive mental health, social support, diagnosis, assessment and intervention for disorders, in ways that diverge from one another and from the culture of the person seeking help. Culturally competent agencies or institutions demonstrate valuing and adapting to cultural diversity, ongoing organizational self-assessment, the institutionalization of cultural knowledge and skills and adapting their service to the needs of culturally diverse consumers and their families. Because of demographic growth in minority populations, disparities will deepen if they are not systematically and urgently addressed.

Proposals are invited for:

1. Innovative approaches among racial and ethnic groups to address mental health issues.
2. Developing ethnic and culture specific therapeutic interventions.
3. Evidence-based treatments specific to ethnic and culturally diverse groups.
4. Engaging minority consumers and families in workforce development, and advocacy.
5. Recruiting racial and ethnic minority and bilingual professionals.

For funding, the PIHP/CMHSP should address possible barriers to care (cultural, linguistic, geographic or economic), provide staffing that reflects the composition of the community being served, and offer training in communication or interviewing skills.

Special Populations
Innovative ideas are encouraged for any special population of persons with serious mental illness, such as women, ethnic minorities, individuals with co-occurring disorders/ mental health/criminal justice needs, who may require unique services and supports based on cultural diversity, ethnic diversity, unique barriers or differences not mentioned in any of the other targeted areas. Special population proposals can address any of the aforementioned categories with the emphasis placed on a special population. When submitting a proposal in this category, please note your submission as a special population proposal with another specialty area focus. As with each specialty area, proposals in this area must demonstrate an effort and direction toward systems transformation and consumer recovery.

ADULTS WITH DEMENTIA

Alyson Rush (517) 335-0250 rusha@michigan.gov

The Michigan Mental Health Code definition of adults with serious mental illness was expanded in 1996 to include individuals who have dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances. The definition includes any other dementia if it occurs in conjunction with another diagnosable serious mental illness. Services may be directed to individuals who have other mental disorders and that promote mental health. The Michigan Mental Health Commission Report of 2004 stated that, "Special outreach efforts need to be targeted to older adults, persons with dementia, and their caregivers."

MDCH is enhancing efforts to improve services to persons with dementia and serious mental illness and improve integration of services between primary, long-term, and behavioral health care. Individuals with a long history of mental illness may develop dementia as they age. Outreach strategies include traditional and innovative techniques to establish trust, rapport, acceptance, and increased use of mental health services by adults at-risk.

Caregivers of older adults with mental illness or progressive disabling medical conditions (including dementia) are also the focus of interventions designed to improve coping skills, mental health needs, reduction of stress, burden, depression, and family conflicts. Programs are encouraged that help caregivers identify ways the environment and caregiver interactions help a person make choices and decisions that meet her/his own needs and desires. As caregivers better

understand the brain functioning and cognitive impairment underlying a person's level of functioning, behavior, and emotional response to events, they will be better able to diffuse stressful situations and to help the person with dementia function in the least restrictive environment and enjoy a higher quality of life.

Many mental health clients have behavior problems that are complicated by cognitive impairments. Programs that increase staff expertise in identifying consumers and addressing the difficult behaviors of people with cognitive impairment related to chronic mental illness, brain injury, and/or dementia can be included in project proposals.

FAMILY PSYCHOEDUCATION ENHANCEMENT

John Jokisch (517) 335-0244 jokisch@michigan.gov

As part of the MDCH FY 05/06 and FY 06/07 Community Mental Health Block Grant, ten (10) of the PIHPs received two years of funding to develop and implement the Family Psychoeducation (FPE) model program that provides sophisticated coping skills for handling problems posed by mental illness through a partnership between consumers and their families.

During the two years of funding, PIHPs engaged in awareness, education, structural and clinical improvements, and adaptation and evaluation activities that focused on strategies for consensus building, enacting and sustaining the FPE model. PIHPs implemented FPE by: 1) obtaining FPE staff training based on the McFarlane model, 2) identifying consumers to participate in the FPE groups, 3) operating FPE groups on a regular basis, 4) participating in consultation and supervision activities through McFarlane staff to maintain model fidelity, and 5) participating in external evaluation efforts to document the model's effectiveness. In addition, PIHP staff involved in FPE participated in the learning collaborative and the FPE subcommittee in an effort to share common experiences. After two years of funding through the block grant, it was expected that the PIHP would continue to provide FPE services through existing agency resources.

As part of the competitive section of this RFP, those PIHPs that have completed two years of block grant funding for FPE may request up to $75,000 for a one year/one-time-only FPE enhancement project. PIHPs requesting funding for this type of project must address the following items:

- The applicant must demonstrate that it continues to offer the FPE services that were established under the initial two years of block grant funding and that all project objectives were met or will be met.

- The applicant must describe the nature of the enhanced project. Specific detail must be provided that distinguishes the enhanced project from the FPE project that the PIHP operated during FY 05/06 and FY 06/07. Possible approaches would be to offer FPE to additional diagnostic populations; combine FPE with another defined clinical practice or treatment such as ACT, medication clinic, etc.; train staff who were trained in FPE to become qualified FPE trainers through train-the-trainer courses; or obtain enhanced video

equipment, teleconferencing equipment, or other technology improvements to improve the existing FPE service.

- The applicant must demonstrate that the enhanced FPE project will adhere to the McFarlane model and describe its methods to provide consultation and supervision to maintain model fidelity.

- The applicant must describe the evaluation methods that it will use to document the enhanced FPE project's effectiveness.

Please note that applications for Enhanced FPE projects are limited to only those ten (10) PIHPs that have completed two years of Block Grant funding for FPE during FY 05/06 and FY 06/07.

PEOPLE WHO ARE HOMELESS

Sue Eby (517) 241-7060 ebys@michigan.gov

Proposals under this category should reflect an ability and readiness to address a homeless population that has demonstrated additional issues of concern, which directly impact their homelessness, such as substance abuse/co-disorder diagnosis. Interventions in this area are intended to address a homeless population who abuses substances and are homeless, those who are homeless and have a mental illness, and those who are homeless and have mental illness issues and require assistance in the areas of mental health assessment, detoxification, life skills training, employment opportunities, and coordination of services for the homeless. A housing first approach is recommended.

Proposals are encouraged that promote outreach, integration of mental health and substance abuse services, prevention services, and support services to individuals in stable housing. Under this category, please note that proposals which propose to provide direct payment of rent, security deposits, utilities, insurance, furnishings, etc., for consumers are not acceptable. Proposals should not be duplication of specific PATH grant focus or intent. Proposals in this area should also promote systems transformation and consumer recovery. Applicants are encouraged to link their projects to the 10-year planning process to end homelessness, PATH, MDCH-MSHDA Chronic MDHS Homeless Initiatives, and MDCH-MSHDA Corporation for Supported Housing Projects.

Projects are encouraged to use the housing assistance described in the Medicaid Provider Manual, Mental Health/Substance Abuse, 17.3.G. Applicants may wish to consult: Substance Abuse and Mental Health Services Administration Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders. DHHS Pub. No. SMA-04-3870, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003. A copy is available at: http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA04-3870/default.asp or the Corporation for Supportive Housing, A Toolkit for Developing and Operating Supportive Housing, located at http://www.csh.org/index.cfm?fuseaction=Page.ViewPage&PageID=3647&

JAIL DIVERSION

Michael Jennings (517) 335-0126 jennings@michigan.gov

Section 207 of the Michigan Mental Health Code requires all CMHSPs to provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. Jail diversion policies and programs are an important public interest consideration. The department's Jail Diversion Policy defines the conditions for establishing and implementing an integrated and coordinated jail diversion program.

Proposals submitted for jail diversion programs must show knowledge of or utilize The Council of State Government's Criminal Justice/Mental Health Consensus Project Report as the basis for systems transformation and consumer recovery. Incorporating Peer Support Specialists in jail diversion service delivery is encouraged. Peer Specialists involved with pre-booking crisis teams or post-booking screening and assessments would be an acceptable strategy. Proposals must go beyond the basic MDCH contract requirements related to jail diversion and implement aspects of the forty-six (46) policy statements contained in the Consensus Report. Proposals that show a strong effort of interagency agreement between the criminal justice system and mental health are encouraged as the criminal justice system is paramount in diversion decisions. Reference material that supports this approach is available from the Consensus Project website at: http://consensusproject.org/pvt/home. The Technical Assistance and Policy Analysis Center (TAPA) provides publications that may be useful to criminal justice and mental health professionals who work with people with mental illness and co-occurring disorders. Their website can be found at www.gainscenter.samhsa.gov.

OLDER ADULTS

Alyson Rush (517) 335-0250 rusha@michigan.gov

Individuals aged 65 and older who have a serious mental illness include the following subsets of hard-to-reach and underserved populations: individuals with serious mental illness; individuals who may be at risk of committing suicide; individuals who develop depression or another type of mental disorder as the direct result of having one or more co-occurring medical conditions or chronic diseases that require active monitoring and different types of medications; and individuals with a co-occurring mental illness and substance use disorder. Also recognized are adults of any age who have dementia with delusions, dementia with depressed mood, dementia with behavioral disturbances or a co-occurring disorder of dementia with a diagnosable mental illness; and family caregivers of isolated older adults with mental illness or progressive, disabling medical conditions.

Recovery is possible for older adults with mental illness when it involves the concept of hope for an improved quality of life and the concept that people with a mental illness and also possibly past employment years may still be able to contribute in meaningful ways to their community. Older adults with mental illness incur the double stigma of mental illness and age, which can serve as a barrier to recognizing, seeking, advocating for, and providing for adequate and helpful

services and supports. Without school attendance and engaging in the workforce, older adults also have a higher degree of isolation and obscurity, along with their family caregivers. Mental health professional staff may not have adequate knowledge of the unique needs of older adults (i.e., sensory loss, multiple medications, loss of natural supports, and dementia).

In FY06, the Michigan Office of Services to the Aging began implementing the Healthy Ideas initiative in response to certain Mental Health Commission recommendations and direction from the Michigan Commission on Services to the Aging. Case managers within the aging network are implementing the program in selected regions. Partnerships with CMHSPs in these initiatives are being developed so that aging network case managers make appropriate referrals, receive consultation, and identify service providers when mental health needs are identified. The "Healthy IDEAS For a Better Life," The National Council on Aging, Center for Healthy Aging, Model Health Programs Toolkit can be found at: http://healthyagingprograms.org/content.asp?sectionid=32&ElementID=40. Partnerships with the aging services network for this initiative and others are encouraged.

Proposals must describe the community partnerships developed to meet multiple needs of older adults with mental illness. Identify existing gaps in the community that are particular to this target population and their caregivers (such as access, availability, and quality of mental health services and supports; improved knowledge and skills) and proposed means of closing those gaps and meeting needs. Proposals may focus on replication of a service model that reflects MDCH values, policies, practice-guidelines or other evidenced-based practices, promising practices and emerging practices. Describe how older adults themselves or their caregivers were involved in the planning of this proposal.

More about the mental health needs of older adults is available at the Older Adult Consumer Alliance website: http://www.oacmha.com/

CERTIFIED PEER SUPPORT SPECIALISTS STAFF DEVELOPMENT

Pam Werner (517) 335-4078 wernerp@michigan.gov

Proposals will be accepted for Certified Peer Support Specialists to receive continuing education, learning, and development. Funding will be provided to assist peers in attending local, regional, statewide, and national training events. All training activities need to be directly connected with the services and supports peers provide as written in the 1915 b(3) additional services. Examples include WRAP training, MDCH-sponsored continuing education events, statewide conferences on person-centered planning, self-determination, housing, consumer conference, evidence-based practices, recovery, etc. National events may include the Alternatives Conference and other events supported by SAMHSA. When applying in this area, please list the number of positions that funding will support and indicate whether the positions are full-time with benefits or part-time.

RECOVERY SYSTEM CHANGE

Colleen Jasper (517) 373-1255 jasper@michigan.gov

Recovery is the foundation of the Michigan public mental health system. In order to create our system of recovery, all participants need to be involved (i.e., administrators, managers, service delivery, consumers, etc.) so that recovery is the focal point of all aspects of the system. Fundamentals of recovery include personal journeys for consumers. The belief in recovery for everyone who has experienced a mental health problem is essential. The Substance Abuse and Mental Health Services Administration has created the ten components of recovery (http://www.samhsa.gov/pubs/mhc/MHC_NCrecovery.htm); this is one way of embracing recovery for all consumers. Promoting recovery can include creative ways that connect with consumers in various localities, levels in the system, and specific and unique needs. Active involvement of consumers in the development, education, and implementation of recovery is critical in the formation of the recovery system of care. Grant requests must show how consumers were instrumental in the development of the proposal.

Examples of recovery-focused initiatives include: education and implementation of Advance Directives, trainings, conferences, staff and consumer joint services, connection to the MDCH Recovery Council, focus groups for recovery inclusion, etc.

SUPPORTED EMPLOYMENT

Su Min Oh (517) 241-2957 ohs@michigan.gov

A PIHP that is not eligible to apply for non-competitive Supported Employment may apply for implementation of evidence-based supported employment under the competitive process. Proposals are required to use the directions and requirements described in the non-competitive Supported Employment section of this RFP.

SUPPORTED HOUSING

Sue Eby (517) 241-7060 ebys@michigan.gov

The provision of Supported Housing has been identified by SAMHSA as an evidence-based practice. Housing ranks as a priority concern of individuals with serious mental illness. Locating affordable, decent, safe housing is often difficult, and out of financial reach. Stigma and discrimination also restrict consumer access to housing. Supported housing focuses on consumers having a permanent home that is integrated socially, is self-chosen, and encourages empowerment and skills development. The services and supports offered are individualized, flexible, and responsive to changing consumer needs. Thus, instead of fitting a person into a housing program "slot," consumers choose their housing, where they receive support services. The level of support is expected to fluctuate over time. With residents living in conventional housing, some of the stigma attached to group homes and residential treatment programs is avoided.

Supported housing may benefit those consumers who previously lived in group homes, are diverted from jail, released from the hospital, currently or previously homeless, etc. Proposals are encouraged that promote outreach; education and training; community linkages; coordination with an existing affordable housing collaborative; and support services to consumers. Under this category, please note that proposals which propose to provide direct payment of rent, security deposits, utilities, insurance, furnishings, etc., for consumers are not acceptable. Proposals should not be duplication of specific PATH grant focus or intent. Applicants are encouraged to link their projects to the 10-year planning process to end homelessness, PATH, MDCH-MSHDA Chronic MDHS Homeless Initiatives, and MDCH-MSHDA Corporation for Supported Housing Projects.

Projects are encouraged to use the housing assistance described in the Medicaid Provider Manual, Mental Health/Substance Abuse, 17.3.G. or the Corporation for Supportive Housing, A Toolkit for Developing and Operating Supportive Housing, located at: http://www.csh.org/index.cfm?fuseaction=Page.ViewPage&PageID=3647&

TRAUMA

Colleen Jasper (517) 373-1255 jasper@michigan.gov

Statistics show that at least 80 percent of consumers with a serious mental illness have had some form of trauma in their life. Addressing trauma early and in conjunction with the treatment of a mental illness is critical in the recovery, growth, and wellness of consumers. A system that is based on being a trauma-informed system of care includes: flexible treatment plans, value of consumers' unique histories, the avoidance of negative care approaches (restraints, seclusion, etc.), positive understanding of coping methods, etc.

The impact of trauma touches many life domains and is life shaping and dramatic. Proposals need to include individuals with a history of trauma in their development and implementation. Education and a knowledge base on innovative approaches to trauma need to be addressed, not only with consumers, but also on all levels throughout the system. New consumers coming into the system and those already in the system need to receive services in a system that is "trauma-informed." A trauma-informed system assumes individuals have had trauma in their histories. Trauma is not the exception.

Trauma initiatives may include: education about trauma, both in the system and community; specialized training with consumers; support groups; organizational changes required to be trauma-informed; awareness of the interactive aspects of mental illness and trauma; and other strategies.

OTHER TYPES OF PROJECTS

Alyson Rush (517) 335-0250 rusha@michigan.gov

There is the expectation that some of the service gaps identified by CMHSPs may not be specifically described in this RFP. Proposals that fit neither the program and/or populations

described may be submitted in this category. Please identify the type of proposal under "Other" on the Face Sheet.

PIHP STATEWIDE COMPETITIVE PROPOSAL FOR CLUBHOUSE TRAINING

This RFP also includes the opportunity for PIHPs to apply for a contract to make training and technical assistance available to Michigan clubhouses. Up to $75,000 in block grant funds is available for each of two years of funding, October 1, 2007 through September 30, 2008 and October 1, 2008 through September 30, 2009. No match dollars are required.

Proposals are requested for innovative ideas for working with all of Michigan's clubhouses to support recovery, promote and secure employment, member leadership and to improve the quality of services provided in clubhouses. One project will be funded. The PIHP that receives the funding is required to provide training opportunities for all of Michigan's 47 clubhouses. Proposals must include:

- Training opportunities that promote employment opportunities for clubhouse members
- Training opportunities that promote member leadership
- Training opportunities that promote recovery, empowerment, and community inclusion
- Training opportunities that strengthen the work-ordered day in clubhouse
- Training opportunities that support implementing outcome evaluation

It is expected that each training opportunity should be at no cost, or at a minimum cost, for consumers. The proposal must include evidence of consumer involvement, collaboration or support in developing, implementing and monitoring the project.

Please refer to the Proposal Requirements for Competitive Proposals section of this RFP for submission requirements. Note: Use the Statewide Clubhouse Training Proposal Narrative/Review Criteria outline for this area.

ATTACHMENT A

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration

FY 2008 COMMUNITY MENTAL HEALTH BLOCK GRANT PROPOSAL FACE SHEET

1. PIHP: _____ CMHSP (if applicable) _____

2. Primary Program Area (from list below): _____

3. Program Area(s) and/or Target Population(s) - *check <u>all areas</u> that apply:*

- ☐ Anti-Stigma
- ☐ Assertive Community Treatment
- ☐ Clubhouse Programs
- ☐ Consumer Run, Delivered, or Directed
- ☐ Co-occurring Disorders – IDDT (non-competitive)
- ☐ Co-occurring Disorders Enhancement (competitive)
- ☐ Cultural Competence / Special Populations
- ☐ Adults with Dementia
- ☐ Family Psychoeducation (non-competitive)
- ☐ Family Psychoeducation Enhancement (competitive)
- ☐ People who are Homeless
- ☐ Jail Diversion
- ☐ Older Adults
- ☐ Certified Peer Support Specialists Staff Development
- ☐ Recovery System Change
- ☐ Supported Employment (non-competitive)
- ☐ Supported Employment (competitive)
- ☐ Supported Housing
- ☐ People with a History of Trauma
- ☐ Other (please specify) _____

4. Type of Project Request: ☐ 1-Year Proposal ☐ 2-Year Proposal ☐ Rural County ☐ Urban County

5. Proposal Information:

a. Project Title: _____

b. Specific counties to be served: _____

c. Summary of service(s) that will be developed: _____

_____

_____

_____

d. Block Grant funding requested:

FY08 Block Grant Funds Requested	FY08 Other / Local Funding (Voluntary)	Total FY08 Funding
$	$	$

FY09 Block Grant Funds Requested	50% Match - **Required** (Except for Non-Competitive EBP Proposals)	FY09 Other / Local Funding (Voluntary)	Total FY09 Funding
$	$	$	$

e. Rank this proposal in relation to the total number of requests submitted by your PIHP: _____ of _____

f. Has this program or project been funded previously with Block Grant funds? ____ If yes, what year(s)? _____

6. Name and telephone number of the individual(s) to be contacted regarding this application in the event the review panel requests changes that will make the proposal appropriate to recommend for funding. **The budget person must have the authority to modify the budget forms. The work plan person must have the authority to modify the work plan.**

	Name	Title	Telephone No.	E-mail Address
PIHP Fiscal Contact Person				
PIHP Workplan Contact Person				

Signature: _____ Date: _____

CMHSP Director (if applicable)

Signature: _____ Date: _____

PIHP Director

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

View at 100% or Larger
Use WHOLE DOLLARS Only

PROGRAM			DATE PREPARED	Page	Of
CONTRACTOR NAME			BUDGET PERIOD From To:		
MAILING ADDRESS (Number and Street)			BUDGET AGREEMENT ☐ ORIGINAL ☐ AMENDMENT ▶	AMENDMENT #	
CITY	STATE	ZIP CODE	FEDERAL ID NUMBER		

EXPENDITURE CATEGORY				TOTAL BUDGET (Use Whole Dollars)
1. SALARIES & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				
6. EQUIPMENT				
7. OTHER EXPENSES				
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	$0	$0	$0	$0
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**

SOURCE OF FUNDS

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**$0**	**$0**	**$0**	**$0**

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385(E) (Rev 5-06) (W) Previous Edition Obsolete.

ATTACHMENT B.2

PROGRAM BUDGET – COST DETAIL SCHEDULE

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM	BUDGET PERIOD From:	BUDGET PERIOD To:	DATE PREPARED
CONTRACTOR NAME	BUDGET AGREEMENT ☐ORIGINAL ☐AMENDMENT		**AMENDMENT #**

1. SALARY & WAGES POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
			$0
			$0
			$0
			$0
			$0
			$0
			$0
	1. TOTAL SALARIES & WAGES:	0	$ 0

2. FRINGE BENEFITS (Specify)

☐ FICA ☐LIFE INS. ☐DENTAL INS. COMPOSITE RATE
☐UNEMPLOY INS. ☐VISION INS ☐WORK COMP. AMOUNT 0.00%
☐RETIREMENT ☐HEARING INS.
☐HOSPITAL INS. ☐OTHER (specify) _____

2. TOTAL FRINGE BENEFITS: $0

3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL: $0

4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS: $0

5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Name Address Amount

5. TOTAL CONTRACTUAL: $0

6. EQUIPMENT (Specify items)

6. TOTAL EQUIPMENT: $0

7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

7. TOTAL OTHER: $0

8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)	**8. TOTAL DIRECT EXPENDITURES:**	$ 0
9. INDIRECT COST CALCULATIONS	**Rate #1: Base $0 X Rate 0.0000 % Total**	$ 0
	Rate #2: Base $0 X Rate 0.0000 % Total	$ 0
	9. TOTAL INDIRECT EXPENDITURES:	$ 0
10. TOTAL EXPENDITURES (Sum of lines 8-9)		$ 0

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0386 (E) (Rev 5-06) (W) Previous Edition Obsolete. Use Additional Sheets as Needed

Co-occurring Disorders: Integrated Dual Disorder Treatment Template for PIHP Planning and Implementation

Please review the following activities related to Co-occurring Disorders: Integrated Dual Disorder Treatment and check the appropriate box indicating where in the process the PIHP is at present.

PIHP: _____

	Activity	Accomplished	In Planning	Not begun
1.	PIHP convenes meetings with other stakeholders including Substance Abuse Coordinating Agencies to address co-occurring disorders.	☐	☐	☐
2.	PIHP identifies a program leader for Co-occurring Disorders: Integrated Dual Disorder Treatment.	☐	☐	☐
3.	PIHP uses the COFIT to assess where the system is with respect to its ability to serve people with co-occurring disorders and develop action plans based on this.	☐	☐	☐
4.	PIHP access centers have profession staffs that are trained to screen for both mental illness and substance disorders.	☐	☐	☐
5.	Individuals entering the mental health system, or receiving ongoing services, are routinely screened for co-occurring substance disorders.	☐	☐	☐
6.	PIHP forms an ongoing work group (a separate workgroup for administrators and clinicians if necessary) to address Co-Occurring Disorders: Integrated Dual Disorder Treatment.	☐	☐	☐
7.	PIHP develops an Action Plan that addresses co-occurring capability for the system as a context for the implementation of the COD: IDDT Resource Kit and includes identified training and technical assistance needs.	☐	☐	☐
8.	PIHP builds ongoing training and teamwork into its system.	☐	☐	☐
9.	PIHP assesses the system at regular intervals using the CoFIT-100.	☐	☐	☐
10.	Providers assess themselves at regular intervals using the COMPASS.	☐	☐	☐

		Accomplished	In Planning	Not begun
11.	PIHP develop a welcoming policy as well as "every door is a right door" policy.	☐	☐	☐
12.	PIHP Action Plan includes steps to reach full implementation to meet fidelity of the Co-Occurring Disorders: Integrated Dual Disorder Treatment Evidence-Based Practice.	☐	☐	☐
13.	PIHP maintains involvement with all relevant regional systems and stakeholder	☐	☐	☐
14.	PIHP provides or arranges for ongoing technical assistance and training needs for PIHP and provider staff.	☐	☐	☐
15.	PIHP identifies areas of needed clinical improvement and works with work groups to address needs.	☐	☐	☐
16.	PIHP shares successes and barriers in Co-Occurring Disorders: Integrated Dual Disorder Treatment implementation with other regions.	☐	☐	☐
17.	PIHP fully implements the Co-Occurring Disorders: Integrated Dual Disorder Treatment Evidence-Based Practice.	☐	☐	☐
18.	Ongoing support for, and measurement of, the IDDT model is maintained using the Michigan Fidelity Assessment Support Team (MiFAST).	☐	☐	☐
19.	PIHP develop and offer the choice of integrated treatment for the entire array of services as well as the availability of IDDT teams to consumers.	☐	☐	☐
20.	PIHP measure outcomes and report data using "HH" and "TG" modifiers.	☐	☐	☐

Family Psychoeducation
RFP Checklist

PIHP Proposal includes:

☐ 1. Description of PIHP team that will implement FPE: names, titles, and roles in implementation, percent of each FTE devoted to the project

☐ 2. Identification of what affiliates (if applicable) and provider networks (if applicable) will participate. Description of their roles.

☐ 3. Evidence that the first four activities in the Consensus Building Awareness Phase (on the FPE Template for PIHP Planning) have begun: a list of all the partners to be included in the development and consensus phase; evidence of collaboration with key stakeholders; evidence of at least one meeting with network; evidence that development of a continuous feedback plan has begun.

☐ 4. A workplan that uses the attached template. If PIHP has begun implementation of FPE, indicate on the workplan the outcomes that have been accomplished in each phase. Workplan should clearly identify phases and activities to be completed, with milestones and dates, specific PIHP staff responsible and intended outcomes.

☐ 5. As applicable, a statement of intent for voluntary involvement in statewide outcomes measurement.

☐ 6. A detailed narrative that indicates how the PIHP will spend the Block Grant funds.

Assurances

The PIHP will:

☐ Support clinicians' participation in FPE training, consultation and supervision that is offered or co-sponsored by MDCH.

☐ Use the SAMHSA Toolkit as basis for implementation.

☐ Participate in fidelity monitoring.

☐ Provide requested quality improvement and satisfaction data to MDCH, or MDCH-sanctioned evaluators.

☐ Properly code encounter data so that MDCH and evaluators may track the utilization of FPE practices.

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase I: Consensus Building **A. Awareness**	1. Create list of all partners to be included in the development & consensus building phase 2. Encourage and collaborate with key stakeholders 3. Identify and use a network from local government, stakeholders, advocacy groups (such as the Depression & Bipolar Support Alliance (DBSA), NAMI, Clubhouses, Drop-in Centers, Mental Health Association), local advisory councils and groups, individual advocates, CMH/PIHP Board Members, PIHP staff 4. Develop a process for obtaining continuous feedback from consumers, families, local NAMI advocates, Clubhouses, drop-in centers, the community and staff	1. March 2007- PIHP selects FPE 2. May 2007- RFP responses due to MDCH	1. PIHP	1. PIHP selected FPE to implement 2. Local program leaders identified 3. Process for obtaining ongoing input from consumers, families and other stakeholders is identified and a three year implementation plan is developed 4. Respond to MDCH RFP

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase I: Consensus Building B. Education	1. Develop local information using SAMHSA toolkit info 2. Develop and disseminate program document resulting from stakeholders discussing materials, using member newsletters and existing member service functions 3. Develop training plan 4. Produce introductory materials 5. Discussion of stakeholders concerns regarding the model and implementation 6. Provide support and training to PIHP staff 7. Disseminate SAMHSA toolkit information & EBP toolkit implementation strategies	1. Summer 2007 2. Summer/Fall 2007	1.PIHP 2. PIHP	1. Consistency in educational materials used in local implementation of FPE 2.Increase stakeholder buy-in and knowledge 3. Training plan is in place
Phase I: Consensus Building C. Structural & Clinical Improvements	1. Develop, revise and implement work flow and other administrative processes 2. Identify information systems requirements 3. Educate Board members and Executive Directors 4. Educate and train staff	1. 6/2007 – 12/2007 - develop & implement plan to revise agency processes as necessary 2. 6/2007 – Information system requirements identified 3. 12/2007 – Information systems can support monitoring and tracking FPE activities 4. Summer/fall 2007- develop & implement plan for Director, Board and staff training	1. PIHP	1.Consistent information systems design to support data collection, aggregation and reporting of data/results 2. PIHPs have developed and made available to staff clinical and administrative supports 3. PIHP will have developed and implemented a plan for training and support
Phase I: Consensus Building D. Adaptation & Evaluation	1.Develop and implement data collection, integration into local QI process and knowledge information system and analysis 2.Review Model: Propose local adaptations which must be reviewed and approved by FPE subcommittee 3.Implement appropriate progress report structure developed by state FPE Subcommittee to test initial fidelity and outcomes measures	1. June 2007 - PIHPs receive fidelity measures from MDCH 2. Aug. 2007 – PI measures introduced with plan for how data will be collected, interpreted, analyzed and what will be done with data 3. Fall 2007 – General Organizational Index	1. PIHP	1. Consistent implementation of data collection procedures for fidelity measures 2. EBP fidelity maintained through careful review of all changes and adaptations to model 3. Consistent implementation of the model through fidelity monitoring

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase II: Enacting A. Awareness	1. Develop plan for continuous feedback on model and service 2. Implement process for obtaining continuous feedback from consumers, family, local NAMI advocates, Clubhouses, Drop-in Centers, the community and staff	1. January 2008	1. PIHP	1.Continuous plan for feedback on model & service developed and implemented 2.Consumers, families and local advocates support the program and demonstrate buy-in by recommending the program to others
Phase II: Enacting B. Structural & Clinical Improvement	1. Implement process to collect and analyze data and identify opportunities for improvement 2. Develop defined competencies for clinical staff	1. January 2008	1. PIHP	1. PIHP uses data to inform decision-making to improve internal processes 2. Core set of clinical competencies identified and training developed to support clinical & administrative improvements
Phase II: Enacting C. Continual Improvement & Support	1. Use performance data to inform all decision-making 2. Enhancements in training needs defined and developed 3. Local implementation of additional EBPs (such as Integrated Treatment of Individuals with Co-Occurring Disorders, ACT, etc.)	1. January 2008 – Report to MDCH 1st year data 2. January – March 2008 – Training needs presented to MACMHB 3. October 2008	1. PIHP staff and quarterly supervision group 2. PIHP 3. PIHP	1. PIHP uses data to inform decision-making to improve internal processes 2. State-wide identified training needs developed and made available to PIHPs 3. Layering of EBP to enhance clinical outcomes for consumers

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase II: Enacting D. Adaptation & Evaluation	1. Analyze fidelity measures and other performance data to make ongoing monitoring and funding decisions 2. Discuss planning for 3rd year of implementation of project	1. January – April, 2008	1. PIHP	Outcomes data: -Consumer satisfaction -Staff satisfaction -Improvement in quality of life for consumers as measured by: reduced hospitalization rates; reduced consumer contacts with the criminal justice system; meaningful involvement in the community; increased consumer compliance with medications; improved participation in treatment process; improved consumer perception of recovery; improvement in meaningful family relationships; increase in number of consumers in supported employment; improved physical health status

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase III: Sustaining: A. Awareness	1. Community is actively involved in the support groups 2. PIHP will develop mechanism to track referrals into the group from the community, consumers and other local stakeholder groups 3. Use data for outreach to consumers and families	1. October 2008 – September 2009	1. PIHP	1. Family and consumer buy-in to program results in referrals to program 2. Process in place for PIHP to count the number of referrals coming from community & consumers
Phase III: Sustaining: B. Education	1. With key stakeholders, provide educational forums to legislative, advocacy and local community groups	1. October 2008 – September 2009	1. PIHP	1.Increased understanding of mental illness by consumers, families and policy makers 2.Improvement of local communities' understanding of mental illness and FPE 3.Involvement of NAMI, consumers and families in FPE's group facilitation
Phase III: Sustaining: C. Structural and Clinical Improvement	1. Build capacity for expansion of groups	1. October 2008 – May 2009:	1. PIHP	1.Of those PIHP that have chosen FPE EBP, 95% of their counties will have implemented FPE by the 3rd year of the project 2. Data collection and monitoring system implemented and fully functional
Phase III: Sustaining: Adaptation & Evaluation	1.Create a local level evaluative capacity to monitor performance against outcomes 2. Identify and document local innovations	1. October 2008 – May 2009 – Data collection and monitoring system implemented and fully functional 2. October 2008 – September 2009	1. PIHP 2. PIHP	1. PIHP share FPE results and outcomes with consumers, community and other interested stakeholders 2. Local innovations documented and shared with FPE Subcommittee and MDCH

Competitive
Proposal Narrative

1. SUMMARY (5 points): Provide a brief summary of the proposed project.

2. NEED IDENTIFICATION AND CONSUMER INVOLVEMENT (15 points): Explain how the need for the proposed project was identified, including how primary consumers had meaningful involvement in the process used to identify the need.

3. RECOVERY (15 points): Address how the project will support consumers in the recovery process. Explain how the project will address the values of Michigan's public mental health system to promote recovery and wellness; reduce stigma; facilitate access; seek support arrangements that facilitate independence, personal responsibility, and full participation in community life; and promote consumer choice.

4. REGIONAL SERVICES (10 points): Explain how the project will assure more uniformity of the availability of evidence-based or improved practices across the PIHP region.

5. SPECIFIC CATEGORY REQUIREMENTS (15 points): Address all special requirements listed in the programmatic specifications contained in the RFP for the primary category for which this proposal is submitted.

6. SUSTAINABILITY (15 points): If this is a service project (all two-year requests), describe the firm commitment from the PIHP/CMHSP that the services will continue after grant funds have ended. Describe how any positions for consumers funded under the proposal will remain in place after the grant period is over.

7. COMMUNITY COLLABORATION (15 points): Describe community collaboration and support in developing, planning, implementing, and monitoring the project. The goal of the collaboration is for consumers to be connected to services and supports needed to meet their needs. Proposals that involve collaboration with other community organizations must include letters of support that specifically describe what and how partners will contribute to the project, both in terms of human and financial commitment.

8. STAFF SUPPORT (15 points): Describe how the planned level of staff support was determined. Include position descriptions of key project personnel. Describe the knowledge and experience of key project personnel related to recovery, the target population, and the proposed intervention. Describe how peer specialists will be involved in the program. Address any requirement or priority for filling key positions with primary consumers.

9. WORKPLAN (15 points): No separate narrative is required here. The workplan will be reviewed for:

   - clear description of the outcomes to be achieved by the project;
   - clear goals statements and measurable objectives;
   - timelines and assignment of responsibility for completion of objectives and activities for each quarter;
   - the number of consumers who will be impacted;
   - a description of the methods that will be used to evaluate the impact of the project, describing the use of data, and the involvement of consumers; and
   - a description of how the results of the project will be shared with MDCH for possible dissemination throughout the state.

10. BUDGET AND BUDGET NARRATIVE (15 points): No separate narrative required here. The budget and budget narrative will be reviewed for:

    - the level of funding requested is reasonable to achieve the proposed outcomes;
    - proposed costs are aligned with project objectives, personnel needs and other resources required to complete project activities;
    - proposed costs are identified as those needed specifically for this project and are not utilized to cover current program capacity; and
    - line item costs are specified.

11. CONTINUATION HISTORY (15 points): Attach to this narrative a list of all block grant funded projects within the PIHP, by CMHSP, with project end dates of 9/30/04, 9/30/05, or 9/30/06 with a description of the current status of each project, including the type of funding used to continue the project started with the block grant.

Statewide Clubhouse Training
Proposal Narrative

1. SUMMARY (5 points): Provide a brief summary of the proposed project.

2. NEED IDENTIFICATION AND CONSUMER INVOLVEMENT (15 points): Explain how the need for the proposed project was identified, including how primary consumers had meaningful involvement in the process used to identify the need.

3. RECOVERY (15 points): Address how the project will support consumers in the recovery process. Explain how the project will address the values of Michigan's public mental health system to promote recovery and wellness; reduce stigma; facilitate access; seek support arrangements that facilitate independence, personal responsibility, and full participation in community life; and promote consumer choice.

4. STATEWIDE SERVICES (15 points): Explain how the project will assure to support training needs and assistance across the Michigan clubhouses.

5. SPECIFIC CATEGORY REQUIREMENTS (15 points): Address all special requirements listed in the programmatic specifications contained in the RFP for Statewide Clubhouse Training

6. STAFF SUPPORT (15 points): Describe how the planned level of staff support was determined. Include position descriptions of key project personnel. Describe the knowledge and experience of key project personnel related to recovery, the target population, and the proposed intervention. Describe how peer specialists will be involved in the program. Address any requirement or priority for filling key positions with primary consumers.

7. WORKPLAN (15 points): No separate narrative is required here. The workplan will be reviewed for:

    - clear description of the outcomes to be achieved by the project;
    - clear goals statements and measurable objectives;
    - timelines and assignment of responsibility for completion of objectives and activities for each quarter;
    - the number of consumers who will be impacted;
    - a description of the methods that will be used to evaluate the impact of the project, describing the use of data, and the involvement of consumers;
    - a description of how the results of the project will be shared with MDCH for possible dissemination throughout the state.

8. BUDGET AND BUDGET NARRATIVE (15 points): No separate narrative required here. The budget and budget narrative will be reviewed for:

- the level of funding requested is reasonable to achieve the proposed outcomes;
- proposed costs are aligned with project objectives, personnel needs, and other resources required to complete project activities;
- proposed costs are identified as those needed specifically for this project and are not utilized to cover current program capacity; and
- line item costs are specified.

9. CONTINUATION HISTORY (10 points): Attach to this narrative a list of all block grant funded projects within the PIHP, by CMHSP, with project end dates of 9/30/04, 9/30/05, or 9/30/06 with a description of the current status of each project, including the type of funding used to continue the project started with the block grant.

THE AMERICAN DREAM – *Because I have had a place where I could live and just be and feel safe, it really accelerated my recovery. (CO 259)*

Basic Material Resources – *I'm stuck. I have to not hardly work at all in order to stay on Medicaid to be able to take care of myself and pay for all those prescriptions and all these doctor bills. (TX 308-311)*

Hinders
Poverty
Unsafe & Unaffordable Housing
Lack of Transportation
Barriers to Benefits & Entitlements
Lack of Communication Services

Helps
Livable Income
Safe & Affordable Housing
Transportation
Information & Advocacy on Services & Benefits/ Insurance Parity
Telephone Service
Resources from Social Networks

CITIZENSHIP – *Often times it's not about pathology, it's just about life. (AZ 739)*

Social Relationships – *Having a friend is a way of feeling comfortable with who I am, having more esteem and respect – esteem and faith in myself and trust to let go and be who I am in a sociable setting. (SC 646)*

Hinders
Inadequate Social Network/ Social Isolation
Emotional Withdraw/ Personal Isolation
Lack of Information for Families and Friends
Controlling Family Members
Lack of Social Skills
Stigma, Prejudice, Labeling, Negative Media Portrayals
Disabling Conditions/ Health Problems
Social Status/ Immigrant Status
Trauma Experiences
Substance Abuse

Helps
Extended Networks/ Kinship Ties/ Friendships/ Affinity Groups (faith communities, tribes)
Personal Ties (at least one person)/Intimate Relationships
Openness to New Information, Strategies, Healing/Advocates within Social Networks
Supportive & Accepting Kin
Communication/ Social Contact (e.g. fun)/ Balancing Solitude and Social Togetherness
Volunteerism
Access to Means of Communication (i.e., phone service, Internet)
Social Choices
Mutual Aid/Interdependence

Meaningful Activities – *The state agency which is supposed to help people with occupational rehab services, told me that because of mental illness, I cannot go to work in the mental health field (which is what I want to do) because I shouldn't be counseling people or I shouldn't be around other people because my illness would prevent me from helping someone else. I'm like, duh, I have a better understanding than anybody else, I think, and I've been working in this field on a volunteer basis as a peer advocate, a mental health advocate. I just want to find a paid position for it. (RI 963-979)*

Hinders
Unemployment/ Role Loss/ Under-Employment/ Limited Range of Jobs
Employment Disincentives in Benefits
Not Respecting Personal Decisions about Job Readiness or Interest
Lack of Training & Education Opportunities
Exploitation of Volunteer Work
Prejudice, Stigma and Discrimination/ Disclosure Fears

Helps
Choice among Meaningful Employment Opportunities
Program and Policy Decision Making
Respect Choices/Readiness for Work
Educational Advancement (e.g., formal, self-directed)
Volunteer Work
Understanding & Respective Employers/ Accommodations
Advocacy Group Participation/ Systems Level Advocacy/ Community Organizing

PERSONHOOD – *Live your life, not your diagnoses. (CO 1309)*

Hope, Sense Of Meaning & Purpose – *Coming to this point where I am saying, "Yeah. I can see a road, and there's a future." (TX 732)*

Hinders
Dreams, Goals, Desires Demeaned
Poor Quality Services/ Cutbacks
Pessimistic Staff
Spirituality Discounted or Ignored
Stigma, Prejudice, Discrimination
Sense of Hopelessness/ Negative Beliefs & Attitudes/ Self-Stigma
Disabling Condition Itself
Unfulfilled Basic Needs
Lack of Education on Recovery Resources

Helps
Developing a Sense of Meaning & Purpose/ Having Goals
Meaningful Service Choices
Staff are Hopeful/ Realistic Optimism
Spirituality Acknowledged
Role Models, Friends & Peers
Positive Personal Attitudes/ Hope, Optimism
Reclaiming & Appreciating Personal Strengthens/ Active Coping
Positive Personal Experiences/ Housing & Sense of Home/ Rejuvenation
Gaining Knowledge and Becoming Educated

Self/Whole Person – *Even if you do get worse, this can be compensated by the skills you learn to manage your illness…even if the illness does get worse, this does not mean that your life gets worse. (UT 699)*

Hinders
Negative Beliefs and Attitudes
Not Taking Personal Responsibility
Invalidation and a Lack of Information
A Lack of Discretionary Funds
Disabling Conditions/ Health Problems
Labeling

Helps
Positive Traits and Attitudes
Self Reliance/Personal Resourcefulness/ Dignity of Risk
Information & Education on Disorder
Self Advocacy and Self Determination
Self Care/ Self-Monitoring of Symptoms
Seeing Self as Whole, Complete Person

EMPOWERMENT PROCESS – *It would be nice if a mental health center would say, "These are the services that we should be able to provide to you. We can't because of funding. But if we could, they might actually be more helpful to your recovery process than what we do have to offer." Because there's something that's really empowering in having at least that knowledge. (OK 856-860)*

Choice – *We've got your treatment program all designed. We don't want your input. Just keep your mouth shut. Sign this thing. This is what you're going to do. (OK 256 257)*

Hinders
Limited or Lousy Options
Lack of Choices regarding Basic Needs (finances, transportation, housing, socially segregated settings)
Unemployment & Underemployment
Lack of Meaningful Involvement in Treatment Planning/ Lack of Right to Refuse Treatment
Limited Treatment Options
Forced Treatment & Coercion
Family & Professional Control
Lack of Skills in Choice Making
Disabling Condition Itself
Stigma/Discrimination/ Self-Stigma

Helps
Meaningful Options
Expansion of Choices regarding Basic Needs
More Job Choices
Educated on Treatment Options & Best Practices/ Self-Directed Planning/ Advanced Directives
Individualized Services & Treatment Planning/ Expanded Options/ Vouchers
The Freedom of Whether and How to Participate in Programs & Services
Self-Determination
Building Skills and Opportunities for Choice Making
Partner with Others in Recovery

Independence – *Fear keeps people from gaining that independence. (TX 1211) Why should you bother trying if, say, you're going to have another major episode of depression and you are going to be thrown back out with the garbage? Why should you even bother trying again? People certainly have no sympathy in society for you. (TX 1218-1220)*

Hinders
Paternalistic Orientation of the System/ Lack of Respect for Experiential Knowledge
Involuntary & Long-Term Hospitalization
Negative Attitudes & Beliefs (Fear, Lack of Confidence)
Risk & Fear of Losing Benefits/ Clinical Supports/ Safety Net
Stereotyping, Prejudice, Discrimination, Labeling

Helps
Making Own Choices and Decisions/ Increased Consumer Voice in System
Self-Determination/ Advanced Directives
Interdependence & Partnership
Having affordable housing, car, job, etc.
Basic Human and Civil Rights & Freedoms

Peer Support (Referent Power) – *Support from others is very important, especially from others who are in the same predicament that you are. They know what you go through. They've been through it, and they survived, which could help you survive. (TX 1258-61)*

The people that helped me the most in the hospital admitted that yes, they were mental health consumers. They were hired and when they were hired no one knew. (OK 2850-22852)

If we could get funding for [peer education], consumers could be less of a burden on a system that's already overburdened. We could restore some of their dignity, self awareness and self responsibility - personal responsibility that is so absolutely necessary to survive in communal living. (OK 1342-1352)

Hinders
Lack of Funding/ Infighting over Limited Funds
Peer Support Not Available in Many Regions, especially Rural
Limited Participation (e.g., same few people participate)
Limited Leadership Development Opportunities
Formal Service Provider and Staff Control/ Not Controlled by Members
Lack of Independent Peer Support Resources
Professional Mistrust of Peer Support
Lack of Transportation

Helps
Adequate Funding for Peer Support
Wide Availability of Peer Support Resources
Diverse Models of Peer Support (e.g., support groups, warm lines, case managers, etc.)
Role Models & Mentors
Exposure to Self-Help/ Self-Help Philosophy
Support Resources run by Consumers
Consumers employed within Traditional/Formal MH Services
Accessing Other Self-Help Supports & Services (e.g., AA, NA)
Sharing Common Experiences

THE FORMAL SYSTEM – *The system should assume that every person that walks through the door has the potential for recovery rather than the opposite – just automatically assume that recovery is possible. (SC 1286)*

Implicitly or explicitly getting the message that you will be sick for the rest of your life, you'll never get well. You'll have to take meds the rest of your life. Being told you'll never work again. The thing that the system has done to hinder and actually damage me the most is tell me I'll never be well. (AZ 2247)

They use meds as a way to control your behavior – it's like a pharmaceutical handcuff – a medication straightjacket. (SC #1334)

We have a system that's based on helping on an emergency basis only. Does it have to take an emergency before somebody gets help? Does it have to be when somebody pulls the trigger or slices their wrist before somebody finds the help that they need? (TX 1275-80)

Formal Services

Hinders – Organizational Culture & Structure
Culture and Organization that is Pathology-Focused/Illness-Focused/ Dominance of Medical Model
Lack of Change & Innovation
Lack of Holistic Orientation (e.g., neglect spirituality, physical health)
Access Limited to Those in Crisis
System promotes Dependency/ Paternalism & Maternalism
Stigma within the System
Social Segregation
Funding Problems
Lack of Consumer Voice on Personal and System levels

Helps – Organizational Culture & Structure
A Recovery-Oriented System with a Vision of Recovery/ Extending Support beyond Traditional Boundaries/ Consumer-Driven
Encourage Innovation/ De-fund or Transform Ineffective Practice & Programs
Holistic Approach/ Proactive Approach supporting Preventative Measures/Positive Mental Health
Multiple Strategies
Self-Responsibility/ Fostering Growth & Interdependence/ Assistance with Letting go of Dependency on System
Fully Committed to Consumer Voice/ Support Risk Taking/ Freedom to Fail
More Tolerance for Diversity & Unusual Behavior
Adequate Funding and Equitable Distribution of Resources/ Monies Reinvested in Community/ Voucher System
Consumers employed within System at all Levels/ Consumers involved in Decision-making Processes such as Staff Hiring & Firing/ Mandated Consumers Positions on Boards & Committees/ Office of Consumer Affairs/ Ombudsman Program

They bend the people to the program instead of bending the program to the people. (NYC 1152)

It's basically just an ushering in and an ushering out—'Here's some meds, we'll see you in 32 days.'" (CO 2633)

Hinders – Programs & Services
Coercion & Forced Treatment
Treatment/Medication used as a means of Social Control
Debilitating Effects & Experiences of Long-Term Hospitalization
Substandard Services/ Poor Quality Assurance
Limited Access to Services & Supports/ Timeliness, Time limits
Fragmentation of Services, Eligibility Restrictions
Lack of Individualization
Lack of Needed Range of Services, Treatments and Options
Lack of Education for Consumers, Family Members and Community (e.g., illness, self-care, services, etc.)
Inadequate Continuity of Care

Help - Programs & Services
Forced Treatment Avoided
Freedom of Whether & How to Participate in Services & Meds/ Self-Management of Medications
Inpatient Services as Last Resort but Available/ Small Scale/ Alternatives to Hospitalization/ Self-Directed Inpatient Care/ Advanced Directives Respected
Quality Clinical Care/ Consumer-Doctor Partnership/ Up-to-date Treatment Knowledge/ Clean & Modern Program Environments
No Waits/ Flexible
Coordinated Services across Problems, Settings, & Systems/ Effective Case Managers with Low Caseloads & High Pay/ Disengagement or Reductions in Services based on Consumer's Self-Defined Needs
Tailored to Individual/ Wide Range of Choices as to Who Provides, What is Provided & Where Provided
Peer Support Services/ Therapy & Counseling/ Atypical Meds/ Family Services/ Employment Support & Career Development/ Respite Care/ Integrated Dual Diagnosis Services/ Jail Diversion and Community Reintegration Services/ Etc.
Patient Education/ Illness Education/ Information on Meds, Effective Treatments & Services & How to Secure, Rights/ Family Education/ Public Awareness Education (anti-stigma & pro-recovery)
System Navigators/ Extensive Out-reach & Support (multiple languages, 24-7, minority-focused)/ Homeless Outreach/ Safety Net Services
Access to Records/ Can Change Inaccurate Information
Early Intervention & Public Screenings/ Outreach to Churches, Schools, Communities

PARTNERSHIP – *The right staff with patience, time and understanding can help you move along toward recovery. (NYC, 239)*

Formal Service System Staff – *The most important thing is a sense of partnership…I remember the first time (and it was very recently… within the last year), that a psychiatrist actually sat down and talked to me, actually listened to what I had to say. I was feeling a lot of fear and apprehension about some important tasks I had in front of me. He said 'We're going to get through this together, you know, this is a team effort.' News to me. Twenty years of living with [this disorder] no one ever told me that before…This concept that we were in partnership –both of us doing whatever we could to enhance my recovery, understanding that the primary responsibility is with me for my own recovery, not stepping back from that at all – was such a novel thing. (AZ 2373)*

I don't want to cry all the time and I want to be able to get out of bed but I don't want to be 950 pounds either. I didn't have this side effect before I took it. Give me the right to tell you what's happening with my body and the medication is not working or else the side effect is much worse than not taking the medication. (OK 634-643).

I had a therapist that cared and this was in the public sector. All those people came together one day to an office at a facility and they all sat down with me and talked about how I was going to survive and how they were going to help me survive. We were all going to decide how we were all going to help me get well. Wrap around, where you're pulling in community, family, faith, work and being holistic. Combining everybody around you who knows about you and everyone being aware of what your symptoms are, how you're behavior is and then it's just like a community taking care of you until you're able to take care of yourself. (Native American describing tribal response, OK 1448-1485)

Hinders
Discontinuity/ Burnout/ Overworked
Low Expectations/Negative Messages
Misunderstanding/Mistrust
Coercion/ Power-Over/ Formal Roles
Paternalism/ No Understanding of Consumer's Experiences/ Superior/ Disrespectful
Culturally Insensitive/ Devaluing/ Not Much Staff Diversity
Foster Dependency/ Discourage & Undermine Consumer Participation
Inadequate Knowledge & Training (on trauma services, recovery process, effective meds & treatments, etc.)

Helps
Continuity/ One-on-one Relationship/ Availability
Hopeful/ Positive Expectations/ Belief that Recovery is Possible
Understanding, Trustworthy/ Honest/ Open
Partnership & Collaboration/ Treated as Equals/ Provides Practical Support using Multiple Roles
Listened to/ Believed/ Staff are Authentic, Respectful, Supportive, Caring, Responsive, Have Humility
Culturally Sensitive/
Fosters Self-Empowerment
Improved & On-going Training & Education/ Consumers Involved as Trainers

Chronicity Compared To Recovery: A recovery-based mental health system strives to implement the ideals of a recovery orientation as compared to the focuses of the old paradigm or chronicity orientation, as detailed in the following table, based on the work of Ridgway (1999)[1].

The Chronicity Paradigm	**The Emerging Recovery Paradigm**
Diagnostic groupings; "Case"; Lumped and labeled as "chronics"/ SPMI/ CMI	Unique identity; Person orientated; Person First Language
Pessimistic Prognosis; "Broken Brain"	Hope and Realistic Optimism
Pathology/ Deficits; Vulnerabilities are Emphasized; Problem-Orientation	Strengths/ Hardiness/ Resilience; Self-Righting Capacities Emphasized
Fragmented Biological/ Psychosocial/ Oppression Models	Integrated Bio-Psycho-Social-Spiritual Holism; Life-context
Professional Assessment of "Best Interests" and Needs/ Paternalism	Self-Definition of Needs and Goals/ Voice/ Consumer-Driven/ Self-determination
Professional Control/ Expert Services	Self-Help/ Experiential Wisdom/ Mutuality/ Self-Care/ Partnering with Professionals
Power Over/ Coercion/ Force/ Compliance	Empowerment/ Choice
Reliance on Formal Supports or "Independence"	Emphasis on Natural Supports; Interdependency
Social Segregation; Formal Program Settings; Deviancy-Amplifying Artificial Settings	Community Integration/Real Life Niches; Accommodation to Natural Community Resources/ In Vivo Services & Supports
Maintenance/ Stabilization; Risk-Avoidance	Active Growth/ New Skills & Knowledge/ Dignity of Risk
Patient/ Client/ Consumer Role	Normative Roles/ Natural Life Rhythms
Resource Limitations/ Poverty	Asset Building/ Opportunities
Helplessness/ Passivity/ Adaptive Dependency	Self-Efficacy/ Self-Sufficiency/Self-Reliance

[1] Source: Ridgway, P. (1999). *Deepening the Recovery Paradigm: Defining Implications for Practice. A Report of the Recovery Paradigm Project.* Unpublished Manuscript. Lawrence, KS: University of Kansas, School of Social Welfare, Office of Mental Health Research and Training.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

March 1, 2007

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Patrick Barrie, PB Deputy Director
Mental Health and Substance Abuse Administration

SUBJECT: Michigan Department of Community Health (MDCH) Recovery Policy and the Role of Peer Support Specialists

It is the policy of MDCH, under the leadership of Director Janet Olszewski and the vision of Governor Jennifer Granholm, to support our system transformation to one based on the fundamental principle of recovery for adults with mental illness. The major emphasis has been creation of the Michigan Recovery Council and the availability of Peer Support Specialists. The Michigan Recovery Council is charged with reviewing all MDCH policies that support or hinder recovery and proposing pro-active changes that will further the goals of this policy directive. On January 19, 2007, I met with the Michigan Recovery Council to emphasize the department's commitment to this major pro-consumer policy and to communicate the department's desire to see each Prepaid Inpatient Health Plan, and Community Mental Health Services Program affiliate to the PIHP (PIHP/CMHSP), implement it as part of its core mission.

MDCH strongly believes that persons who have received our services have a valuable perspective on how to help others. Consequently, we believe that by employing them as Peer Support Specialists, we will strengthen our system of support. This department direction was reflected in the scoring of the Application for Participation for the Medicaid Specialty Services Program. Since 1998, Mental Health Block Grant funds have been awarded to PIHP/CMHSPs to employ primary consumers to work with peers in their recovery journeys. A key finding from the block grant experience was the need to establish a mechanism to continue the positions when grant funding ended. Last year, the Centers for Medicare and Medicaid Services (CMS) approved the inclusion of Peer Support Specialists as a service offered under the authority of 1915 (b)(3).

These changes in the Specialty Services Waiver require that each PIHP/CMHSP provide the availability of a Peer Support Specialist as an option during the person-centered planning process. To minimally comply with the requirements of the waiver, each PIHP/CMHSP in the state must assure that consumers have a choice of peer

specialists at the PIHP/CMHSP or through its contract agencies. We acknowledge and applaud the PIHP/CMHSPs that have employed a large number of individuals in both part and full-time positions. These early adopters have been quick to recognize and support the importance of this grass roots movement and are working to change organizational practices necessary to make this a mainstream practice. Key areas that require attention are health care coverage, benefits, adequate salary levels, a mix of both full and part-time positions and supporting an organizational culture of recovery with special attention to the removal of "micro assaults" that result in Peer Support Specialists being treated in a disrespectful manner.

Michigan is receiving strong national attention regarding both our vision and the Medicaid funding mechanism developed to support the employment of Peer Support Specialists. I have directed the Bureau of Community Mental Health Services, led by Irene Kazieczko, to carry out this effort. MDCH has made significant efforts to support full and part-time employment opportunities for people with mental illness as Peer Support Specialists. Since 2005, MDCH has covered all of the expenses for training, testing and certifying Peer Support Specialists across the state. The training requirements are both intensive and comprehensive. The feedback we receive from consumers and their families gives us even greater reason to trust the wisdom of furthering our commitment to this core policy. At the recent awards ceremony in December, peers and their guests celebrated the achievement both individually and collectively as the new movement grew with 127 individuals certified in the state. This is our future. To not improve and expand on this transformation would be a major disservice to the people we work to serve each and every day.

Although certification is not currently required, we believe that in the next year or two we will have an adequate number of trained and certified peers in the workforce to meet the demands of beneficiaries statewide. At that point, we will provide notification of the requirement for certification.

As you are aware, MDCH will have four more trainings this year in March, April, May and July. We also have begun supporting continuing education efforts by developing a partnership with the Copeland Center for Wellness and Recovery. At some of the upcoming trainings, a full week of learning will be provided for 18 Certified Peer Support Specialists to become WRAP Facilitators who will receive certification by the Copeland Center. All of these activities will persist as Michigan continues to support recovery as the foundation to service planning. We will continue to provide training and certification activities as a service to the PIHP/CMHSPs, Peer Support Specialists, and beneficiaries across the state. If you have any questions regarding the Peer Support Specialist initiative, please contact Pam Werner. She can be reached at (517) 335-4078 or wernerp@michigan.gov. For consultation and technical assistance on recovery, Colleen Jasper, Director of the Office of Consumer Relations, would be happy to help you. She may be contacted at (517) 373-1255 or jasper@michigan.gov. We expect to add further resources to these efforts to support systems transformation.

No one person, department, or agency can take sole credit for the success of this program to date. But we can all take a moment to feel good about the part that each of us has played. It has been a collaborative effort where consumers, PIHP/CMHSPs, MDCH and stakeholders sat down and talked, shared concerns, made changes, took risks and eventually came to establish programs that better serve people in need. We can take great pride in establishing a program that has improved service to consumers. We should also feel pride that Michigan was asked to write a chapter in the soon to be released SAMHSA Toolkit for Peer Supports. This chapter highlights the journey of many peers and contains quotes from certified peers working across the state. When the toolkit is published, we will notify all PIHP/CMHSPs across the state.

As we celebrate the success of peers, we are also aware of the barriers that exist at the local level. Many of you must grapple with them on a daily basis. MDCH is committed to working with you in resolving them by providing statewide training and technical assistance. However, many of the barriers that need to be addressed must be done locally in partnership with the Peer Support Specialists. To the extent that the services of MDCH are both needed and desired, we are firmly committed to assisting in these efforts.

I look forward to working with each of you in your leadership efforts to support this system transformation.

cc: Janet Olszewski
Recovery Council Members and Partners
Certified Peer Support Specialists in Michigan
MDCH Mental Health and Substance Abuse Management Team